

4811

## CERTIFICATE OF DEATH

04800

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>				c. LENGTH OF STAY IN 1b <b>35yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Oscar Preston Alston</b>				4. DATE OF DEATH <b>April 18 19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb 7 1894</b>	9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trucker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hauling trash</b>		11. BIRTHPLACE (State or foreign country) <b>Petersburgh, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Preston Alston</b>				14. MOTHER'S MAIDEN NAME <b>Isabella Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-10-3484</b>		17. INFORMANT <b>Horace Alston</b> Address <b>518 W. 161st Apt 24 New York City 32 N.Y.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b> <b>157x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug</b> , 19 <b>58</b> , to <b>April</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 18</b> , 19 <b>59</b> , and that death occurred at <b>4:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>302 W. POTOMAC ST</b> DATE SIGNED <b>4-20-59</b>							
ACTUAL SIGNATURE <b>John D. Turco</b>		M.D. <b>302 W. POTOMAC ST</b>		DATE SIGNED <b>4-20-59</b>			
PHYSICIAN'S NAME (Type) <b>JOHN D. TURCO</b>		ADDRESS <b>HAGERSTOWN, MD</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-22-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Watson Jr. Hagerstown Md</b>				24a. REC'D BY REGISTRAR <b>APR 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

04799

Reg. Dist. No.

4812

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>WASH. FREE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLETOWN</u> <u>10X-2</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>STATE HOSP.</u>			d. STREET ADDRESS <u>113 E. MAIN ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lelia</u> Middle <u>Frances</u> Last <u>Andrews</u>			4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1959</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3/12/1908</u>		9. AGE (In years last birthday) <u>51</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>WILLIAM SMITH</u>			14. MOTHER'S MAIDEN NAME <u>CARRIE LITTEN</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-24-8012</u>		17. INFORMANT <u>Mrs. Lelia V. Stine</u> Address <u>Middletown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema + peritonitis</u> 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized carcinomatosis</u> DUE TO (c) <u>ovarian carcinoma</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 mos.</u> <u>13 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 25</u> , 19 <u>59</u> , to <u>April 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 7</u> , 19 <u>59</u> , and that death occurred at <u>6:05 P.</u> M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>George Beren</u>		ADDRESS (Street, city or town, state) <u>1500 PENNSYLVANIA AVE.</u>		DATE SIGNED <u>4/8/59</u>	
PHYSICIAN'S NAME (Type) <u>DR. G. BEREN</u>		<u>HAGERSTOWN, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraus</u>			ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 '59</u>
					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

DATE OF DEATH

PLACE OF DEATH

NAME

WILLIAM SMITH

AGE

10

MALE

STATE

MARYLAND

SEX

WHITE

10

31

VIRGINIA

22

WILLIAM SMITH

GRABIE

11

NO

THE STATE OF MARYLAND

WILLIAM SMITH

10

10

10

10

10

10

10

10

10

10

ROSE HILL

WILKINSON

NO

THE STATE OF MARYLAND

10

10



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4813 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04801

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>16 Hrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. County Hospital</u>			e. STREET ADDRESS <u>near Funkstown</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>OSCAR MASON ARTZ</u>			4. DATE OF DEATH Month Day Year <u>April 22 1959</u> 19		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan'y 5 1874</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		11. BIRTHPLACE (State or foreign country) <u>Md. Downsville Wash. Co</u>	
13. FATHER'S NAME <u>Samuel Artz</u>			14. MOTHER'S MAIDEN NAME <u>Harriett Stiffler</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Howard M. Artz Hagerstown Md. R # 3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>902.5</u> DUE TO <u>Fractured Skull(closed) &amp; shock</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell over wagon</u>			
20c. TIME OF INJURY Month, Day, Year <u>10:30 p.m. Apr. 22 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	
				20f. (City or town) (County) (State) <u>Rural Funkstown Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>4-23-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>			24a. REC'D BY REGISTRAR <u>APR 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BACILLARIE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1

NAME OF DECEASED: [illegible]

AGE: [illegible]

SEX: [illegible]

RACE: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

TIME OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DIAGNOSIS: [illegible]

ATTENDING PHYSICIAN: [illegible]

DATE: [illegible]

SIGNATURE: [illegible]

OFFICIAL SEAL: [illegible]

## CERTIFICATE OF DEATH

04802

Reg. Dist. No.

4814

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>669 Forest Drive</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY CATHERINE BAKER</b>				4. DATE OF DEATH Month Day Year <b>April 23 19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 10, 1902</b>		9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		11. BIRTHPLACE (State or foreign country) <b>Myersville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Philip Barnes</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Weddles</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-16-0571</b>		17. INFORMANT Address <b>Mrs. R. B. Nicklas 220 N. Potomac St. Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cerebral Hemorrhage</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>20 days 12 hrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>None 19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) <b>-</b>		(County) <b>-</b>	(State) <b>-</b>
21. I certify that I attended the deceased from <b>Apr. 4, 1959</b> , to <b>Apr. 23, 1959</b> , that I last saw the deceased alive on <b>Apr. 23, 1959</b> , and that death occurred at <b>8:30 p. m.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b> DATE SIGNED <b>4-24-59</b>			
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>				<b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/27/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hauer</b>	

Wm. C. Host O-Puo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4815

CERTIFICATE OF DEATH

04803

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b>		c. LENGTH OF STAY IN 1b <b>1 Month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Violet</b> Middle <b>May</b> Last <b>Baker</b>		4. DATE OF DEATH Month <b>4</b> Day <b>29</b> Year <b>19 59</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 29. 1914</b>
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min.	IF UNDER 24 HRS. Hours <b>6</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Mt. Union Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Swan</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Williams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Charles M Baker</b>		Address <b>132 E. Main St. Hancock Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>hepatic coma</b> DUE TO <b>260x</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>diabetes</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>several weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/17/59</b> , 19____, to <b>4/29/59</b> , 19____, that I last saw the deceased alive on <b>4/29/59</b> , 19____, and that death occurred at <b>12 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>136 North Potomac St. 5/1/59</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Howard N. Weeks</b>		M.D. <b>136 North Potomac St. 5/1/59</b>	
PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b>		<b>Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5.2.59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland Allegany Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard N. Weeks</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 14

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4816

CERTIFICATE OF DEATH

Reg. Dist. No. 04804

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Fulton</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burnt Cabins 75x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Kathryn</u> Middle <u>Kell</u> Last <u>Baldwin</u>				4. DATE OF DEATH Month <u>Apr.</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 14, 1895</u>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>20</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Shade Gap, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer E. Kell</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Neil</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>C. Stull Baldwin, Bt. Cabins, Pa.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>292.4 aplastic anemia</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar. 19</u> , 19 <u>59</u> , to <u>Apr. 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Apr. 3</u> , 19 <u>59</u> , and that death occurred at <u>1:40 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>H/5/59</u> DATE SIGNED <u>—</u>							
ACTUAL SIGNATURE <u>R. S. Stauffer</u>				M.D. <u>145 S. Prospect St</u>			
PHYSICIAN'S NAME (Type) <u>R. S. STAUFFER</u>				<u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 7, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Orbisonia</u>		22d. LOCATION (City, town, or county) (State) <u>Orbisonia Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Linsinger, Mercersburg, Pa.</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>APR 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. King</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4817

## CERTIFICATE OF DEATH

04805

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Franklin</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Scott</b> Last <b>Barr</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5, 1959</b>
9. AGE (In years lost birthday) yrs. <b>1</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>David H. Barr</b>		14. MOTHER'S MAIDEN NAME <b>Judith A. Fox</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>David H. Barr, RFD 3, Greencastle, Pa.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Atelectasis</b> 762.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Prematurity (omas)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/5/59</b> , 19, to <b>4/6/59</b> , 19, that I last saw the deceased alive on <b>4/6/59</b> , 19, and that death occurred at <b>2 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>SEARL M. VOON</b>		DATE SIGNED <b>4/7/59</b>	
PHYSICIAN'S NAME (Type) <b>SEARL VOON MD Hagerstown</b>		ADDRESS (Street, city or town, state) <b>148 M. Patomac</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>4-8-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Salem Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			

2081201XVI

4817

CERTIFICATE OF DEATH

481805

Washington

Hanna

Franklin

Legation

1 day

Greenacres

Washington County Hospital

HPD 63

David Scott Carr

April 6, 1959

Male White

April 25, 1959

1

David H. Carr

Janith A. Carr

David H. Carr, HPD 3, Greenacres, Pa.

6

1

*Handwritten signature and notes*

Burial - 4-8-59 - Salem Church Cemetery, Hagerstown, Md.

Scott P. Carrington & Son, Hagerstown, Md.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 302										
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>4 Hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R # 5</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. County Hospital</u>					d. STREET ADDRESS <u>Leitersburg</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>ESTHER KUHN BAUMGARDNER</u>					4. DATE OF DEATH Month Day Year <u>April 26 1959 19</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 14 1897</u>		9. AGE (In years last birthday) <u>61</u> yrs.		
						IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Houdewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Kuhn</u>					14. MOTHER'S MAIDEN NAME <u>Mary Hamburg</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Frank B. Baumgardner Hagerstown R #5</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined -- pending Autopsy report</u> DUE TO <u>970.8</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Poisoning due to overdose of Potassium Thiocyanate</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Took over dose of Blood pressure pills</u>						
20c. TIME OF INJURY Month, Day, Year Hour <u>xxx</u> <u>Noon</u> p. m. <u>4-26-59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at home</u>		20f. (City or town) <u>Hagerstown</u>		(County) <u>Wash</u>		
(State) <u>Md</u>										
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>										
ACTUAL SIGNATURE <u>S. Robert Wells</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED <u>4-27-59</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Waynesboro Franklin Co Pa</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>					24a. REC'D BY REGISTRAR DATE <u>APR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Huns</u>			

04806

Reg. Dist. No. 302

4818

081

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2

2. COUNTY  
3. CITY

4. SEX

5. AGE

6. OCCUPATION

7. DATE OF EXAMINATION

8. NAME OF EXAMINER

9. SIGNATURE OF EXAMINER

10. SIGNATURE OF PATIENT

11. SIGNATURE OF WITNESS

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF NURSE

14. SIGNATURE OF ASSISTANT

15. SIGNATURE OF CLERK

16. SIGNATURE OF RECEPTIONIST

17. SIGNATURE OF LABORATORY

18. SIGNATURE OF RADIOLOGIST

19. SIGNATURE OF PATHOLOGIST

20. SIGNATURE OF HISTOLOGIST

21. SIGNATURE OF CYTOLOGIST

22. SIGNATURE OF MICROSCOPIST

23. SIGNATURE OF X-RAY

24. SIGNATURE OF PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF MATH

1. NAME OF PATIENT

2. ADDRESS

3. CITY

4. STATE

5. ZIP CODE

6. DATE OF BIRTH

7. SEX

8. OCCUPATION

9. DATE OF EXAMINATION

10. NAME OF EXAMINER

11. SIGNATURE OF EXAMINER

12. SIGNATURE OF PATIENT

13. SIGNATURE OF WITNESS

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF NURSE

16. SIGNATURE OF ASSISTANT

17. SIGNATURE OF CLERK

18. SIGNATURE OF RECEPTIONIST

19. SIGNATURE OF LABORATORY

20. SIGNATURE OF RADIOLOGIST

21. SIGNATURE OF PATHOLOGIST

22. SIGNATURE OF HISTOLOGIST

23. SIGNATURE OF CYTOLOGIST

24. SIGNATURE OF MICROSCOPIST

25. SIGNATURE OF PHYSICIAN

26. SIGNATURE OF NURSE

27. SIGNATURE OF ASSISTANT

28. SIGNATURE OF CLERK

29. SIGNATURE OF RECEPTIONIST

30. SIGNATURE OF LABORATORY

# 1 M 090 4880 04807 Reg. Dist. No. 1. PLACE OF DEATH a. COUNTY *Washington* MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Williamsport* c. LENGTH OF STAY IN 1b *1 yr 6 mos* d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION *Williamsport Sanitarium* 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE *West Virginia* b. COUNTY *Martinsburg* c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *85 x -3* d. STREET ADDRESS *224 S. Tennessee Ave.* e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ 3. NAME OF DECEASED (Type or print) *Catherine Reesor Blundel* First Middle Last 4. DATE OF DEATH *April 14 1959* Month Day Year 5. SEX *Female* 6. COLOR OR RACE *White* 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. B. DATE OF BIRTH *Dec 8, 1858* 9. AGE (In years last birthday) *100 yrs.* IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Housewife* 10b. KIND OF BUSINESS OR INDUSTRY *At Home* 11. BIRTHPLACE (State or foreign country) *Pennsylvania* 12. CITIZEN OF WHAT COUNTRY? *U. S. A.* 13. FATHER'S NAME *John Gerhart* 14. MOTHER'S MAIDEN NAME *Emmeline Reesor* 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) *None* 16. SOCIAL SECURITY NO. *None* 17. INFORMANT *Mrs. Catherine Reesor (Daughter)* Address *224 S. Tenn. Ave. Martinsburg, W. Va.* 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) *Congestive Heart Failure* *422.1* DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) *Arteriosclerotic Cardiovascular Disease* DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) *None* 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. *19* 20d. INJURY OCCURRED While ☒ at work Nat while ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from *Aug 1, 1958* to *April 14, 1959*, that I last saw the deceased alive on *April 14, 1959*, and that death occurred at *11 P.* M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) *28 W Potomac* DATE SIGNED *April 14, 1959* ACTUAL SIGNATURE *M Byrd* M.D. PHYSICIAN'S NAME (Type) *Williamsport Md* 22a. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 22b. DATE THEREOF *April 17, '59* 22c. NAME OF CEMETERY OR CREMATORY *Green Hill Cemetery* 22d. LOCATION (City, town, or county) (State) *Martinsburg, W. Va.* 23. FUNERAL DIRECTOR'S SIGNATURE *Albert L. Leaf Williamsport, Md* ADDRESS 24a. REC'D BY REGISTRAR *APR 17 '59* 24b. REGISTRAR'S SIGNATURE *Arthur S. Kneass*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

## CERTIFICATE OF DEATH

1920

Name of Deceased [Illegible]		Sex [Illegible]		Age [Illegible]	
Date of Birth [Illegible]		Place of Birth [Illegible]		Date of Death [Illegible]	
Cause of Death [Illegible]		Place of Death [Illegible]		Date of Burial [Illegible]	
Signature of Physician [Illegible]		Signature of Registrar [Illegible]		Signature of Coroner [Illegible]	
Signature of Medical Examiner [Illegible]		Signature of Health Officer [Illegible]		Signature of [Illegible]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4819

## CERTIFICATE OF DEATH

04808

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>washington</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. LENGTH OF STAY IN lb <i>47 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		12-24-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Western Md. State Hospital</i>		d. STREET ADDRESS <i>553 Girard street</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>ETHEL</i> Middle <i>(unknown)</i> Last <i>Boston</i>		4. DATE OF DEATH Month <i>April</i> Day <i>20</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>September 4, 1890</i>
9. AGE (In years last birthday) <i>68</i> yrs.		10. IF UNDER 1 YEAR Months <i>-</i> Days <i>-</i> Hours <i>-</i> Min. <i>-</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>maid</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
13. FATHER'S NAME <i>Will Stansbury</i>		14. MOTHER'S MAIDEN NAME <i>Martha Frederick</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>unknown</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Informant</i> Address <i>Patient</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia, bilateral</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last: (b) <i>Pulmonary edema and congestion</i> DUE TO (c) <i>arteriosclerotic cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>5 days</i> <i>several years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>① Hypertension, essential ② cerebral sclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 4</i> , 19 <i>59</i> , to <i>April 20</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>April 20</i> , 19 <i>59</i> , and that death occurred at <i>2:45 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Victor L. Ramos</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>Western Md. State Hospital April 20, 1959</i>	
PHYSICIAN'S NAME (Type) <i>Victor L. Ramos</i>		<i>Hagerstown, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/25/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. James Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Havre de Grace Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E. Bullenk</i>		24a. REC'D BY REGISTRAR DATE <i>APR 28 '59</i>	
ADDRESS <i>Havre de Grace, Md</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i>	



41308

CERTIFICATE OF DEATH

41308

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4881

## CERTIFICATE OF DEATH

04809

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FAIRPLAY RURAL</b> c. LENGTH OF STAY IN 1b <b>LIFE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FAIRPLAY RURAL</b> d. STREET ADDRESS <b>FAIRPLAY MD. R.1 (RICHARD ROAD)</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGE WASHINGTON SHOWMAN BOYER</b>		4. DATE OF DEATH <b>APRIL - 16, 1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 31 - 1877</b>	9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>		11. BIRTHPLACE (State or foreign country) <b>TAYLORS LANDING WASH. CO. MD. U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>CHARLES E. BOYER</b>		14. MOTHER'S MAIDEN NAME <b>ANNA CATHERINE ARTZ</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. HARRIET SHOWMAN FAIRPLAY MD. R.1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Day</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Day</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>415-59</b>	
20f. (City or town) <b>415-59</b>		20g. (County) <b>415-59</b>		20h. (State) <b>415-59</b>	
21. I certify that I attended the deceased from <b>4/15/59</b> 19____, to <b>4/16/59</b> 19____, that I last saw the deceased alive on <b>4/16/59</b> 19____, and that death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Dr. J. H. Young</b>		M.D. <b>William J. Young</b>		DATE SIGNED <b>4/17/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. J. H. Young</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>APRIL 19, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. VIEW CEMETERY</b>	
22d. LOCATION (City, town, or county) <b>SHARPSBURG WASH. CO. MD.</b>		22e. (State) <b>MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Best</b>		ADDRESS <b>BOONSBORO MD.</b>		24a. REC'D BY REGISTRAR <b>APR 21 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove supporting papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4820

CERTIFICATE OF DEATH

04810

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN TB <b>Since 3-11-59</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>				d. STREET ADDRESS <b>108 East Fifth Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARGARET BRUST</b>				4. DATE OF DEATH Month Day Year <b>APR. 2 1959</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 11, 1893</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Ephriam Fogle</b>				14. MOTHER'S MAIDEN NAME <b>Harriett Albaugh</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Ethel B. Brust (Same as item #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema + congestion</b> <b>154x</b> DUE TO <b>Left, lower lobe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Lobular pneumonia + small pulmonary embolus</b> DUE TO <b>4 "</b> (c) <b>Carcinoma of rectum + pelviometastasis</b> <b>6 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hydronephrosis</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 11, 1959</b> , to <b>April 2, 1959</b> , that I last saw the deceased alive on <b>April 2, 1959</b> , and that death occurred at <b>3:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Western Md. State Hospital April 2, 1959</b>							
ACTUAL SIGNATURE <b>Victor L. Ramos</b>				M.D. <b>Western Md. State Hospital</b>			
PHYSICIAN'S NAME (Type) <b>VICTOR L. RAMOS</b>				<b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-6-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>APR 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thoms</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be signed as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

Items 18-21 Film 242 3-6-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04811

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 14 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1318 Glenwood Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sylvester J Buckler		4. DATE OF DEATH Month Day Year 4 18 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1912
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) furniture finisher		10b. KIND OF BUSINESS OR INDUSTRY Brandts	
11. BIRTHPLACE (State or foreign country) St. Marys' County, Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Isiah Buckler		14. MOTHER'S MAIDEN NAME Agnes Tippet Hill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-26-2139	
17. INFORMANT Mrs. Alice Buckler		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 970.2 Undetermined pending autopsy report DUE TO (b) Acute Phenobarbital Poisoning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Aspiration of vomitus		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Took over dose of Phenobarbital tablets	
20c. TIME OF INJURY Month, Day, Year Hour Minute p.m. 4-17-59 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home		20f. (City or town) (County) (State) Hagerstown Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4-20-59	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-21-59	
22c. NAME OF CEMETERY OR CREMATORY St. Pauls		22d. LOCATION (City, town, or county) (State) Hagerstown Rural Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE APR 22 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hous	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
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100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

4822

## CERTIFICATE OF DEATH

04812

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN TB <b>2 hours 15 min. X</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>TERRY</b> Middle <b>LEE</b> Last <b>BUTTS</b>				4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 9, 1959</b>		9. AGE (In years lost birthday) yrs. <b>2</b>	IF UNDER 1 YEAR Months <b>15</b> Days <b>2</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Raymond Butts</b>				14. MOTHER'S MAIDEN NAME <b>Frances L. Shank</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Raymond Butts</b> Address <b>Hagerstown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5 atelectasis</b> DUE TO (b) <b>Immaturity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							INTERVAL BETWEEN ONSET AND DEATH
21. I certify that I attended the deceased from <b>April 10, 1959</b> , to <b>April 10, 1959</b> , that I last saw the deceased alive on <b>April 10, 1959</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b> DATE SIGNED <b>4/10/59</b> ACTUAL SIGNATURE <b>F. J. Done Jr.</b> M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/10/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> <b>A. Suter-Rouzer</b>				24a. REC'D BY REGISTRAR DATE <b>APR 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

2081355XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Figure 1

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4823 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04813  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>24 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>71 Nottingham Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ARCHIE</b> Middle <b>OWEN</b> Last <b>CAUFFMAN</b>		4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1909</b>
9. AGE (In years last birthday) <b>49 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School Board</b>	
11. BIRTHPLACE (State or foreign country) <b>Blue Ridge Summit, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arthur C. Cauffman</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Nagle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>no</b>		16. SOCIAL SECURITY NO. <b>220-10-3019</b>	
17. INFORMANT <b>Mrs. Retha H. Cauffman</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>33/x</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arterio Sclerosis</b> (c) <b>Arterio Sclerosis</b> DUE TO cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>Apr. 14/59</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None.</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>None</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>None</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>J. H. Beachley</b>		DATE SIGNED <b>4/16/59</b>	
EXAMINER'S NAME (Type) <b>J. H. Beachley</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/18/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>APR 22 '59</b>	
ADDRESS <b>Hagerstown, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hous</b>	



HEALTH DEPT.  
FOR STATE

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		RESIDENCE	
JAMES C. GARDNER		Baltimore, Md.	
AGE		SEX	
35		Male	
DATE OF DEATH		PLACE OF DEATH	
July 20, 1933		Home	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
DISEASE OR INJURY		DISEASE OR INJURY	
Myocardial Infarction		Myocardial Infarction	
PREVIOUS ILLNESS		PREVIOUS ILLNESS	
None		None	
SIGNS AND SYMPTOMS		SIGNS AND SYMPTOMS	
Sudden death		Sudden death	
FINDINGS AT AUTOPSY		FINDINGS AT AUTOPSY	
None		None	
TESTS		TESTS	
None		None	
LABORATORY		LABORATORY	
None		None	
SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER	
J. C. Gardner		J. C. Gardner	
DATE		DATE	
July 20, 1933		July 20, 1933	
PLACE		PLACE	
Baltimore, Md.		Baltimore, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4824

### CERTIFICATE OF DEATH

04814

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		d. STREET ADDRESS <u>1 921 A Main Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR DURMAN CHILDRESS</u>		4. DATE OF DEATH Month Day Year <u>April 16 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 14 1872</u>
9. AGE (In years lost birthday) yes. <u>86</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Holland Furnace</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick H. Childress</u>		14. MOTHER'S MAIDEN NAME <u>Martha (no record)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-8875</u>	
17. INFORMANT Address <u>Mrs Essie V. Childress 921 A Main Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177X</u> DUE TO <u>Carcinoma Prostate &amp; Metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Grand Arterial aneurysm</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hagerstown Md.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>one year</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-1-59</u> , to <u>4-16-59</u> , that I last saw the deceased alive on <u>4-13-59</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. Switzer</u>		DATE SIGNED <u>4/17/59</u>	
PHYSICIAN'S NAME (Type) <u>IRENE WITTO</u>		ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 21 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

STANDARD FORM NO. 100-1

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES A. SMITH		2. SEX Male	
3. AGE 65		4. RACE White	
5. DATE OF DEATH April 15, 1968		6. TIME OF DEATH 10:30 AM	
7. PLACE OF DEATH Home		8. CAUSE OF DEATH Heart Disease	
9. MANNER OF DEATH Natural		10. SIGNATURE OF PHYSICIAN J. H. Jones	
11. SIGNATURE OF REGISTRAR M. B. Smith		12. SIGNATURE OF WITNESSES J. H. Jones, M. B. Smith	
13. SIGNATURE OF DECEASED James A. Smith		14. SIGNATURE OF NEXT OF KIN John A. Smith	
15. SIGNATURE OF CLERK M. B. Smith		16. SIGNATURE OF DECEASED James A. Smith	
17. SIGNATURE OF DECEASED James A. Smith		18. SIGNATURE OF DECEASED James A. Smith	
19. SIGNATURE OF DECEASED James A. Smith		20. SIGNATURE OF DECEASED James A. Smith	
21. SIGNATURE OF DECEASED James A. Smith		22. SIGNATURE OF DECEASED James A. Smith	
23. SIGNATURE OF DECEASED James A. Smith		24. SIGNATURE OF DECEASED James A. Smith	
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99. SIGNATURE OF DECEASED James A. Smith		100. SIGNATURE OF DECEASED James A. Smith	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04815

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport,</b>			c. LENGTH OF STAY IN 1b <b>28 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R # 2</b>				d. STREET ADDRESS <b>/ R # 2</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Franklin</b> Last <b>Clark</b>				4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>1959</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-24-73</b>		
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>86</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farming -Self</b>		11. BIRTHPLACE (State or foreign country) <b>Wash. County</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin Clark</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Harmon</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>218-24-1271</b>		17. INFORMANT Address <b>David Anderson- R # 2 Williamsport, Md</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary thrombosis</b> <b>420.1</b> DUE TO <b>Arteriosclerotic coronary heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced generalized arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b> INTERVAL BETWEEN ONSET AND DEATH _____								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>APRIL-23-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN WASH. CO. MD.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. East</b>				ADDRESS <b>BOONSBORO MD.</b>		24a. REC'D BY REGISTRAR <b>DAVID R 4 '59</b>		
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hana</b>				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4825

## CERTIFICATE OF DEATH

04816

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LUTHER GEORGE COSS</b>		4. DATE OF DEATH <b>April 7 1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1894</b>
9. AGE (In years last birthday) <b>64 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Roofer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Roofing contractor</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William S. Coss</b>		14. MOTHER'S MAIDEN NAME <b>Annie K. Justice</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-2476</b>	
17. INFORMANT <b>William C. Coss</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple pulm. emboli</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arr. fibrillation, Cardiac failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1-2 weeks, years.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>29 JUNE</b> , 1958, to <b>7 APRIL</b> , 1959, that I last saw the deceased alive on <b>6 APRIL</b> , 1959, and that death occurred at <b>2:40 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Richard T. Binfard</b> <b>1135 POTOMAC AVENUE</b> <b>7 APRIL, 1959</b>			
ACTUAL SIGNATURE <b>Richard T. Binfard</b> M.D. <b>1135 POTOMAC AVENUE</b> <b>7 APRIL, 1959</b>			
PHYSICIAN'S NAME (Type) <b>RECHARD T. BINFORD, M. D.</b> <b>HAGERSTOWN, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/9/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Ronzer Funeral Home</b> <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										04817	
Item 8 Film G241, 4/9/59 fcy										4826	
CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH o. COUNTY <b>WASHINGTON COUNTY</b> <b>Western Md. Hosp.</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			3V01-4		✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Md Hosp.</b>					d. STREET ADDRESS <b>2644 Edmondson Ave</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>WEBSTER</b> Last <b>COX</b>					4. DATE OF DEATH Month <b>APRIL</b> Day <b>3</b> Year <b>1959</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 13 1904</b>		9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>M.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Wright Cox</b>					14. MOTHER'S MAIDEN NAME <b>Mariah Cox</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO.		INFORMANT Address <b>Ellen Dorden 2644 Edmondson Ave.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>191.5 Pulmonary Congestion &amp; Edema</b> DUE TO (b) <b>Carcinoma of Anus - Metastases</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Vascular Accident</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>MAR. 20</b> , 19 <b>59</b> , to <b>APR. 3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>APR. 3</b> , 19 <b>59</b> , and that death occurred at <b>8:55 A.M.</b> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>Evaristo R. Landry</b> M.D.					ADDRESS (Street, city or town, state) DATE SIGNED <b>1500 Pennsylvania Ave 4/3/59</b>						
PHYSICIAN'S NAME (Type) <b>EVARISTO R. LANDRY, M.D.</b>					<b>Hagerstown, Md.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>			22b. DATE THEREOF <b>4/8/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Annapolis County Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Holstead-Morley</b>					ADDRESS <b>928 E. North Ave.</b>		24a. REC'D BY REGISTRAR <b>APR 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>		

11211

CERTIFICATE OF DEATH

11211

NO. 11211

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

BIRTH

DEATH

INTERMENT

TESTIFY

SIGNATURE

WITNESSES

CLERK

REGISTRAR

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COMMISSIONER

OF

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4883

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairplay Md RFD #1</b>		c. LENGTH OF STAY IN 1b <b>15 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairplay Md RFD #1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Fairplay</b>				d. STREET ADDRESS <b>Fairplay</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Reba</b> Middle <b>Elizabeth</b> Last <b>Crampton</b>				4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 28 1888</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>16</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Henry Swain</b>				14. MOTHER'S MAIDEN NAME <b>Anna Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		INFORMANT Address <b>Mr. Oliver Crampton Fairplay Md RFD #1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/14/59</b> to <b>4/14/59</b> , that I last saw the deceased alive on <b>4/14/59</b> , and that death occurred at <b>6:30 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Fairplay Md</b> <b>4/15/59</b>							
ACTUAL SIGNATURE <b>Robert Lee Williams</b>		M.D.		DATE SIGNED <b>4/15/59</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 17-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Sharpsburg Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert Lee Williams</b>				ADDRESS <b>Fairplay Md</b>		24a. REC'D BY REGISTRAR DATE <b>APR 17 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur L. Brown</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal.



04814

CERTIFICATE OF DEATH

4883

San Antonio

San Antonio

San Antonio

San Antonio

San Antonio

San Antonio

San Antonio

San Antonio

San Antonio

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1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4827

## CERTIFICATE OF DEATH

04819

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>FREDERICK</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u> 10-11-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN Md State Hospital</u>		d. STREET ADDRESS <u>406 BROADWAY</u>	
3. NAME OF DECEASED (Type or print) First <u>MORRIS</u> Middle <u>CROMWELL</u> Last <u>CROMWELL</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLOR</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 7 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MOSES CROMWELL</u>		14. MOTHER'S MAIDEN NAME <u>SALLIE FRYE</u> UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> 420.1 DUE TO <u>ESSENTIAL VASCULAR HYPERTENSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>UNKNOWN</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CORONARY ATHEROSCLEROSIS, CEREBRAL THROMBOSIS</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 6</u> , 19 <u>59</u> , to <u>APRIL 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>APRIL 9</u> , 19 <u>59</u> , and that death occurred at <u>7:40 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Evaristo R. Laddizabal</u> M.D.		ADDRESS (Street, city or town, state) <u>1500 PENNSYLVANIA AVE</u> DATE SIGNED <u>4-10-59</u>	
PHYSICIAN'S NAME (Type) <u>Evaristo R. Laddizabal</u>		<u>Hagerstown Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4-13-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Anatomy Board of Md.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 14 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04820

4828

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN Md STATE Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Luther</u> Last <u>DANNER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 19, 1895</u>
9. AGE (In years last birthday) yrs. <u>63</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph DANNER</u>	
14. MOTHER'S M maiden NAME <u>Elizabeth Daffell</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NO</u>		INFORMANT <u>Hospital</u> Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>526X</u> <u>Confluent Lobular pneumonia, bilateral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple lung abscess, left lower lobe</u> DUE TO (c) <u>Bronchiectasis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>6 WEEKS</u> <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY EMPHYSEMA</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 10</u> , 19 <u>59</u> , to <u>April 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 25</u> , 19 <u>59</u> , and that death occurred at <u>7:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Evaristo R. Radicabal</u> M.D.		ADDRESS (Street, city or town, state) <u>1500 PENNSYLVANIA AVE</u>	
PHYSICIAN'S NAME (Type) <u>Evaristo R. Radicabal</u>		DATE SIGNED <u>4-27-59</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-29-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BURIAL</u>	22d. LOCATION (If in Maryland, give nearest town) <u>BARRITTSVILLE, Md</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>B Lee Flete</u>		24a. REC'D BY REGISTRAR <u>APR 30 '59</u>	
ADDRESS <u>Brunswick Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

01580

DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

1958

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Time of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Signature of physician: \_\_\_\_\_

11. Signature of registrar: \_\_\_\_\_

12. Date of registration: \_\_\_\_\_



## CERTIFICATE OF DEATH

04821

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1108 Carroll Hgts. Blvd.</b>		d. STREET ADDRESS <b>1108 Carroll Hgts. Blvd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Duffey</b>		4. DATE OF DEATH Month <b>4</b> Day <b>26</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 2, 1884</b>
9. AGE (In years lost birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Southern Shoe Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>George Duffey</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Sayles</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-09-3797</b>	
INFORMANT <b>George Knott</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra-abdominal, cervical, and pulmonary</b> <b>200.1</b> DUE TO <b>metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Lymphosarcoma, left inguinal region</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>6 wks.</b> <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic &amp; Hypertensive cardiovascular disease</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 3</b> , 19 <b>58</b> , to <b>April 26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 26</b> , 19 <b>59</b> , and that death occurred at <b>7:45 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>DST 100 Professional Arts Bldg.</b> DATE SIGNED <b>4/27/59</b>			
ACTUAL SIGNATURE <b>[Signature]</b>		M.D. <b>William T. Layman, M.D.</b>	
PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>		<b>Hagerstown Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>4-29-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

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CENTRAL TO CHAIN

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1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4830

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04822

Reg. Dist. No. 302

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>5 Yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1033 Main Ave</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>1033 Main Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>MATTIE CHRISTMAS OCKER DYE</u> First Middle Last			4. DATE OF DEATH Month Day Year <u>April 24 1959</u> 19		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 25 1892</u>	9. AGE (in years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Eaton</u>			14. MOTHER'S MAIDEN NAME <u>Mary Clem</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>John J. Ocker 77 Devonshire Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>					INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>None 19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u> 20f. (City or town) (County) (State) <u>- - -</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. S. Robert Wells, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-25-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		24a. REC'D BY REGISTRAR DATE <u>APR 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

OR STATE  
DEATH CERTIFICATE

MASSACHUSETTS

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO MAKE THE NECESSARY MEDICAL STATEMENTS.  
IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF VITAL RECORDS, DEPARTMENT OF HEALTH, COMMONWEALTH OF MASSACHUSETTS, AT THE PLACE OF DEATH.  
IT IS TO BE RETURNED TO THE PHYSICIAN OR OTHER PERSON QUALIFIED TO MAKE THE NECESSARY MEDICAL STATEMENTS.

1930  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CITY	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MEDICAL EXAMINER		DATE	
OFFICE OF THE REGISTRAR OF VITAL RECORDS		DEPARTMENT OF HEALTH		COMMONWEALTH OF MASSACHUSETTS	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04823

Reg. Dist. No.

4831

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Cambria</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	c. LENGTH OF STAY IN lb <b>4 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Johnstown 75x-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Co. Hospital</b>		d. STREET ADDRESS <b>321 Penrod St.</b>	
3. NAME OF DECEASED (Type or print) <b>David John Eastlake</b>		4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 29 1940</b>
9. AGE (In years last birthday) <b>18 yrs.</b>		IF UNDER 1 YEAR Months <b>18</b> Days <b>11</b>	IF UNDER 24 HRS. Hours <b>11</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		<b>Johnstown Penna.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Johnstown Penna.</b>			
13. FATHER'S NAME <b>Raymond C. Eastlake</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Blickenstaff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>183-30-5370</b>	
		17. INFORMANT <b>Raymond C. Eastlake</b> Address <b>Johnstown Penna.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured pelvic bones</b> <b>816X</b> DUE TO <b>Fractured Femur (left-open)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ruptured bladder and diaphragm</b> DUE TO <b>Pneumonia (terminal)</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>14hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driving automobile and collided with cement truck</b>	
20c. TIME OF INJURY Month, Day, Year <b>1:40</b> Hour <b>Apr. 7</b> 19 <b>59</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Jefferson Blvd.</b>	20f. (City or town) (County) (State) <b>Hagerstown Wash. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>April 12 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-15-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Forest Lawn Mem. Park</b>	22d. LOCATION (City, town, or county) (State) <b>Johnstown Penna.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son Hagerstown Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 15 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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4884

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES Franklin EYMAN</u>				4. DATE OF DEATH Month Day Year <u>April 26 1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14, 1866</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Eyman</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Wayne</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>Mr. C. Wayne Eyman Pittsburg, Penna.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infectious Hepatitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>092x</u> DUE TO (c) <u>4 wks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Refractile Anemia — Cystitis (Chronic)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <u>Aug 1, 1958</u> to <u>April 26, 1959</u> , that I last saw the deceased alive on <u>April 24, 1959</u> , and that death occurred at <u>6:22</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M E Byrkit</u>				ADDRESS (Street, city or town, state) <u>28 W Potomac</u>			
PHYSICIAN'S NAME (Type) <u>Max E. Byrkit</u>				DATE SIGNED <u>4-26-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 30 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

City of Boston

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
M. E. O'Connell		45		Male		White		1922		Boston, Mass.	
Cause of Death		Disease		Injury		Poison		Other		Remarks	
Heart Disease		Myocardial Infarction									
Occupation		Residence		Date of Birth		Date of Marriage		Date of Baptism		Date of Burial	
Carpenter		1234 Main St.		1877		1900		1905		1922	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister		Signature of Undertaker		Signature of Burial Officer	
J. J. O'Connell		M. E. O'Connell		J. J. O'Connell		J. J. O'Connell		J. J. O'Connell		J. J. O'Connell	



4832

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>49 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>120 North Avenue</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>120 North Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LAURA</b> First <b>RAGAN</b> Middle <b>FOCKLER</b> Last 4. DATE OF DEATH <b>April</b> Month <b>13</b> Day <b>19</b> Year <b>59</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>April 15, 1890</b> 9. AGE (In years last birthday) <b>68</b> yrs. IF UNDER 1 YEAR: Months <b>6</b> Days <b>13</b> Hours <b>19</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>meat Market</b> 11. BIRTHPLACE (State or foreign country) <b>Wilson, Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George S. Fockler</b> 14. MOTHER'S MAIDEN NAME <b>Laura K. Mitchell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <b>214-09-1883</b> 17. INFORMANT <b>Miss. Bessie M. Fockler</b> Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic Heart Disease.</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 yrs.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. m. _____ p. m. _____ 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>Aug. 18, 1956</b> to <b>Apr. 13, 1959</b> , that I last saw the deceased alive on <b>April 13, 1959</b> , and that death occurred at <b>7:30P M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 North Potomac St.</b> DATE SIGNED <b>4-14-59</b> ACTUAL SIGNATURE <b>R.A.B ell, M.D.</b> PHYSICIAN'S NAME (Type) <b>Hagerstown, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>4/16/1959</b> 22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Cemetery</b> 22d. LOCATION (City, town, or county) <b>St. Paul Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Super-Houzer Funeral Home</b> ADDRESS <b>Hagerstown, Maryland</b> 24a. REC'D BY REGISTRAR <b>APR 16 '59</b> DATE 24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11032

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Figure 2

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**Dr. J. C. L. J.**

15052 • 37/2

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4833

## CERTIFICATE OF DEATH

04826

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1/2 hour</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>29 1/2 East Franklin Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HORACE CLAY FOGLE</b>		4. DATE OF DEATH <b>April 27 19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 27, 1915</b>
9. AGE (In years last birthday) <b>43 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>	11. BIRTHPLACE (State or foreign country) <b>Thurmont, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Roy I. Fogle</b>	
14. MOTHER'S MAIDEN NAME <b>Miriam E. Foreman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>W.W. II</b>	
16. SOCIAL SECURITY NO. <b>266-36-0220</b>		17. INFORMANT <b>Mrs. Dorothy Fogle</b> Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis.</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio sclerotic Heart Disease</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10-31</b> , 19 <b>55</b> , to <b>4-27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4-25</b> , 19 <b>59</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above. (4-27) ADDRESS (Street, city or town, state) <b>214 N. Potomac St. Hagerstown, Md.</b> DATE SIGNED <b>4/27/59</b>			
ACTUAL SIGNATURE <b>Lloyd A. Hoffman</b> M.D.		PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/29/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> ADDRESS <b>Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 30 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Business Development

1990-1991

## BALTIMORE, 18

4834

## CERTIFICATE OF DEATH

04827

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>1 Month</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Henry</b> Last <b>Fowler Jr</b>				4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1902</b>	9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR Months <b>56</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Downsville, Wash. Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel H. Fowler, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Rose Anna King Md.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>220-05-6828</b>		INFORMANT Address <b>Mrs. Irene C. Fowler, 1220 Wabash Avenue Hagerstown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONFLUENT lobular pneumonia, rt. lung</b> 161X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>carcinoma of the larynx with regional metastasis</b> DUE TO (c) <b>metastasis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>  <b>9 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary emphysema</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 14, 1959</b> to <b>April 14, 1959</b> that I last saw the deceased alive on <b>April 14, 1959</b> , and that death occurred at <b>12:02 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Victor L. Ramos</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>Western Md. State Hospital April 14/59</b>			
PHYSICIAN'S NAME (Type) <b>Victor L. Ramos</b>				<b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/18/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bakersville, Wash. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR <b>APR 17 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4835

## CERTIFICATE OF DEATH

04828

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 Hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES ELLSWORTH FRANK Sr</u>		4. DATE OF DEATH Month Day Year <u>April 6 1959 19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6 1893</u>
9. AGE (In years lost birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Train Dispatcher</u>	11. BIRTHPLACE (State or foreign country) <u>Md</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>W.M.R.R.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William W. Frank</u>		14. MOTHER'S MAIDEN NAME <u>Florence Ginnimah</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>714-05-6836</u>	
17. INFORMANT <u>Alice M. Frank</u>		Address <u>141 W Franklin St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>3 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-1</u> , 19 <u>58</u> , to <u>4-6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-5</u> , 19 <u>59</u> , and that death occurred at <u>9:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles E. Hess</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Smithsburg, Md. 4-9-59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/9/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hess</u>	



CERTIFICATE OF DEATH

Form No. 10-57

PLACE OF DEATH HOME		SEX F	
DATE OF DEATH JAN 10 1958		TIME OF DEATH 11:00 AM	
PLACE OF BIRTH BALTIMORE, MD		AGE 78	
OCCUPATION RETIRED		MARITAL STATUS MARRIED	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF DECEASED (If known)		SIGNATURE OF WITNESS (If known)	
SIGNATURE OF PHYSICIAN (If known)		SIGNATURE OF CORONER (If known)	
SIGNATURE OF REGISTRAR (If known)		SIGNATURE OF CLERK (If known)	

ALL INFORMATION ON THIS CERTIFICATE IS TO BE MAINTAINED IN THE DEPARTMENT OF HEALTH RECORDS AND IS TO BE AVAILABLE TO THE PUBLIC UPON REQUEST.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4836

CERTIFICATE OF DEATH

Reg. Dist. No.

04829

303

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 Yrs</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1032 View St</b>				d. STREET ADDRESS <b>1032 View St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PETER GUSTAV FRITZE</b>		4. DATE OF DEATH <b>April 26 1959</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec 18 1933</b>		9. AGE (In years last birthday) <b>25</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		12. KIND OF BUSINESS OR INDUSTRY <b>---</b>		13. BIRTHPLACE (State or foreign country) <b>Zulichu Germany</b>		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. FATHER'S NAME <b>Ernest Fritze</b>				16. MOTHER'S MAIDEN NAME <b>Katherine Klose</b>			
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		18. SOCIAL SECURITY NO. <b>88-26-0039</b>		19. INFORMANT <b>Ernest Fritze 1032 View St Hagerstown</b>			
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkins Disease</b> <b>201X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		21. INTERVAL BETWEEN ONSET AND DEATH <b>18 mo.</b>		22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
25a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		25b. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		25c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		25d. (City or town) (County) (State)	
26. I certify that I attended the deceased from <b>March 25 1959</b> to <b>April 26 1959</b> , that I last saw the deceased alive on <b>April 25 1959</b> , and that death occurred at <b>7:10 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>		ADDRESS (Street, city or town, state) <b>159 W. Washington St., Hagerstown, Md.</b>					
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		DATE SIGNED <b>4/27/59</b>					
27a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		27b. DATE THEREOF <b>4/29/59</b>		27c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		27d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md</b>	
28. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				29a. REC'D BY REGISTRAR <b>APR 30 1959</b>		29b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4837

CERTIFICATE OF DEATH

Reg. Dist. No.

04830  
302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>42 Yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>800 So Potomac St</u>	
d. STREET ADDRESS <u>800 So Potomac St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MOSES</u> Middle <u>PHILIP</u> Last <u>GARONZIK</u>		4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan'y 20 1873</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Grocery store</u>	
11c. BIRTHPLACE (State or foreign country) <u>Riga Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathan Garonzik</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Singer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-32-5425</u>	
17. INFORMANT <u>Mrs Ida L. Garonzik</u>		Address <u>800 So Potomac St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 12, 1956</u> to <u>April 29, 1959</u> , that I last saw the deceased alive on <u>April 28, 1959</u> , and that death occurred at <u>4:00P</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.A.B ell</u>		DATE SIGNED <u>5-1-59</u>	
PHYSICIAN'S NAME (Type) <u>R.A.B ell, M.D.</u>		ADDRESS (Street, city or town, state) <u>119 North Potomac Street</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/1/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>B'Nai Abraham Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		24a. REC'D BY REGISTRAR <u>MAY 4 '59</u>	
ADDRESS <u>Hagerstown Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	







18840

CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write <b>Williamsport</b> ) RURAL and give nearest town)				c. LENGTH OF STAY IN 1b <b>68 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>10 W. Salisbury Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Rachel</b> Middle <b>Melinda</b> Last <b>Gaylor</b>				4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11 1890</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months <b>11</b> Days <b>28</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>John Harsh</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Newcomer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Mr. Grayson Newcomer Williamsport Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) DUE TO <b>Crown by Throat Boar</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/11/59</b> , 19 <b>59</b> , to <b>4/18/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4/18/59</b> , 19 <b>59</b> , and that death occurred at <b>1:30 PM</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>R. F. Young</b> M.D. <b>Williamsport Md</b> DATE SIGNED <b>4/19/59</b> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 11-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Long Williamsport, Md</b>				24a. REC'D BY REGISTRAR DATE <b>APR 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4885

CERTIFICATE OF DEATH

04833

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dargan</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Dargan</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence</b>				d. STREET ADDRESS <b>RFD#1, Harpers Ferry, W.Va.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>SARAH</b> <b>VIRGINIA</b> <b>GIFFIN</b>				4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 26, 1885</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Franklin Huff</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Pierce</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Samuel E. Giffin</b> Address <b>RFD #1, Harpers Ferry, West Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardio-vascular disease</b> 5 Yrs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>36 Hrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>4/27/59</b> , 19____ to <b>4/28/59</b> , 19____, that I last saw the deceased alive on <b>4/27/59</b> , 19____, and that death occurred at <b>10:45 P</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sharpsburg, Md.</b> DATE SIGNED <b>April 30, 1959</b>							
ACTUAL SIGNATURE <b>Walter H. Shealy</b>				M.D. <b>Sharpsburg, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Walter H. Shealy M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/2/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Samples Manor Cemetery Samples Manor, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Donald Cackley</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Name]		SEX [Male/Female]		AGE [Age]	
DATE OF DEATH [Date]		PLACE OF DEATH [Place]		TIME OF DEATH [Time]	
OCCUPATION [Occupation]		CAUSE OF DEATH [Cause]		MANNER OF DEATH [Manner]	
PLACE OF BIRTH [Place]		DATE OF BIRTH [Date]		TIME OF BIRTH [Time]	
NAME OF FATHER [Name]		NAME OF MOTHER [Name]		NAME OF SPOUSE [Name]	
NAME OF PHYSICIAN [Name]		NAME OF NURSE [Name]		NAME OF ATTENDING CLERGYMAN [Name]	
NAME OF BURIAL PLACE [Name]		NAME OF CEMETERY [Name]		NAME OF FUNERAL HOME [Name]	
NAME OF CORPSE RECEPTOR [Name]		NAME OF CORPSE DELIVERER [Name]		NAME OF CORPSE DISPOSER [Name]	
NAME OF CORPSE PREPARATOR [Name]		NAME OF CORPSE CARRIER [Name]		NAME OF CORPSE BURIALER [Name]	
NAME OF CORPSE CREMATOR [Name]		NAME OF CORPSE INCINERATOR [Name]		NAME OF CORPSE INTERMENT [Name]	
NAME OF CORPSE RECEPTION [Name]		NAME OF CORPSE DELIVERY [Name]		NAME OF CORPSE DISPOSAL [Name]	
NAME OF CORPSE PREPARATION [Name]		NAME OF CORPSE CARRIAGE [Name]		NAME OF CORPSE BURIAL [Name]	
NAME OF CORPSE CREMATION [Name]		NAME OF CORPSE INCINERATION [Name]		NAME OF CORPSE INTERMENT [Name]	
NAME OF CORPSE RECEPTION [Name]		NAME OF CORPSE DELIVERY [Name]		NAME OF CORPSE DISPOSAL [Name]	
NAME OF CORPSE PREPARATION [Name]		NAME OF CORPSE CARRIAGE [Name]		NAME OF CORPSE BURIAL [Name]	
NAME OF CORPSE CREMATION [Name]		NAME OF CORPSE INCINERATION [Name]		NAME OF CORPSE INTERMENT [Name]	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4839

## CERTIFICATE OF DEATH

04834

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. STREET ADDRESS <b>242 S. Potomac Street</b>	
3. NAME OF DECEASED (Type or print) <b>THELMA MILLER GILLECE</b>		4. DATE OF DEATH <b>April 30 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27, 1902</b>
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Funkstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dallas Miller</b>		14. MOTHER'S MAIDEN NAME <b>Steela R. Little</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Margaret V. Reardon</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>hepatic coma</b> <b>581.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Portal Cirrhosis</b> DUE TO (c) <b>Chronic alcoholism</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>4 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1-29</b> , 19 <b>59</b> , to <b>4-30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4-30</b> , 19 <b>59</b> , and that death occurred at <b>4:30 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John D. Tuxio</b>		ADDRESS (Street, city or town, state) <b>302 N. Potomac St HAGERSTOWN, MD</b>	
PHYSICIAN'S NAME (Type) <b>John D. Tuxio</b>		DATE SIGNED <b>4-30-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/2/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hancock, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE MAY 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Thomas</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

CENTRAL STATE OF DEATH

Washington

Washington

Washington County Hospital

THURSDAY

Female White

Hoodsville

Major William

Home

Mr. William A. Wilson

Spokane, Idaho

Spokane, Idaho

W.A.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4887

## CERTIFICATE OF DEATH

04835

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Hook</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Hook</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence</b>				/d. STREET ADDRESS <b>U.S. Route # 340</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>SOPHIA</b> Last <b>HARRISON</b>				4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 8, 1878</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Yarrowsburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John David Fouch</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth West</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Miss Junie Harrison</b> <b>RFD # 1, Knoxville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Heart Failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Occlusion</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b> <b>9 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)				
20c. TIME OF INJURY Hour a. j. _____ p. m. _____ Month _____ Day _____ Year <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) _____ (State) _____		
21. I certify that I attended the deceased from <b>May 12, 1959</b> to <b>4/21, 1959</b> , that I last saw the deceased alive on <b>4/20, 1959</b> , and that death occurred at <b>11:20 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. B. Cooper</b> M.D.				ADDRESS (Street, city or town, state) <b>Brunswick, Md.</b>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED <b>4/24/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/24/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bolivar, Jefferson Co., W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. Donald Eckles</b>				24a. REC'D BY REGISTRAR DATE <b>APR 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Orlando L. Huns</b>	



4888

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>36 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WHITE HALL RT.#1 HAGERSTOWN</b>		d. STREET ADDRESS <b>WHITE HALL RT.#1 HAGERSTOWN</b>	
3. NAME OF DECEASED (Type or print) First <b>VALLIE</b> Middle <b>ARMENIA</b> Last <b>HARSHMAN</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>18</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/14/1877</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>BOONSBORO MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>HENRY LEE HOOVER</b>	
14. MOTHER'S MAIDEN NAME <b>SARAH EASTERDAY</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MR. EMERSON HARSHMAN</b> Address <b>HAGERSTOWN RT.#3 MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Heart D</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Belated Thrombo-Phlebitis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs</b> <b>April 6 1959</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 11, 1952</b> to <b>April 18, 1959</b> that I last saw the deceased alive on <b>April 18, 1959</b> , and that death occurred at <b>7:20 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>SIDNEY NOVENSTEIN</b> M.D. <b>4-20-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/21/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>
22d. LOCATION (City, town, or county) <b>HAGERSTOWN</b>		(State) <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.J. Normant</b> ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 22 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04837

Reg. Dist. No. 302

FOR STATE  
HEALTH DEPT.

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>128 East Washington St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>GRAMMS</b> Last <b>HAWTHORNE</b>			4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>19 59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 30, 1894</b>	9. AGE (In years last birthday) <b>64 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>George W. Watts</b>			14. MOTHER'S MAIDEN NAME <b>Ann Gramms</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mr. Lawson P. Hawthorne</b> Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>none 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	
20f. (City or town) <b>-</b>		20g. (County) <b>-</b>		20h. (State) <b>-</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4-22-59</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/23/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Hagerstown, Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>		ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 27 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haus</b>					

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11-13-31  
JOS. J. JONES

Name of Deceased		John J. Jones	
Age		45	
Sex		Male	
Race		White	
Marital Status		Married	
Occupation		Teacher	
Residence		328 East Washington St., Baltimore, Maryland	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Time of Death		June 10, 1931	
Place of Death		Home	
Physician		Dr. J. J. Jones	
Medical Examiner		J. J. Jones	
Signature		[Signature]	
Date		June 10, 1931	
City		Baltimore	
State		Maryland	
County		Baltimore	
District		North	
Ward		1	
Block		12	
Lot		15	
Section		1	
Sub-section		1	
Tract		1	
Block		12	
Lot		15	
Section		1	
Sub-section		1	
Tract		1	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

04838  
302

4841

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>40 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>416 Guilford Ave</b>				d. STREET ADDRESS <b>416 Guilford Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MOLLY</b> Middle <b>CATHERINE</b> Last <b>HECK</b>			4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>1959</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>sept 27 1871</b>		9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>Co USA</b>	
13. FATHER'S NAME <b>Samuel Henry Boyer</b>				14. MOTHER'S MAIDEN NAME <b>Minerva Ann McCoy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Francis Heck 111 King St</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 2, 1957</b> , to <b>Apr. 28, 1959</b> , that I last saw the deceased alive on <b>April 21, 1959</b> , and that death occurred at <b>8:00 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. A. Bell</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>119 North Potomac St. Apr. 29, 1959</b>					
PHYSICIAN'S NAME (Type) <b>R. A. Bell.</b>		Hagerstown, Maryland.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/1/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

CERTIFICATE OF DEATH

Form 100-10

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 170	
11. DATE OF DEATH June 6, 1968		12. TIME OF DEATH 10:00 AM		13. PLACE OF DEATH Memphis, Tennessee		14. CAUSE OF DEATH Gunshot wound		15. MANNER OF DEATH Homicide	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF NEXT OF KIN John D. Ray		18. SIGNATURE OF PHYSICIAN Dr. J. H. Jones		19. SIGNATURE OF CORONER Mr. A. B. Smith		20. SIGNATURE OF WITNESSES Mr. C. D. Brown, Mr. E. F. Green	

21. MEDICAL HISTORY No previous illness.		22. PRESENT ILLNESS Gunshot wound to the chest.		23. TREATMENT First aid, surgery.		24. HOSPITAL Grady Hospital, Memphis.		25. PHYSICIAN Dr. J. H. Jones	
26. SIGNATURE OF DECEASED (None)		27. SIGNATURE OF NEXT OF KIN John D. Ray		28. SIGNATURE OF PHYSICIAN Dr. J. H. Jones		29. SIGNATURE OF CORONER Mr. A. B. Smith		30. SIGNATURE OF WITNESSES Mr. C. D. Brown, Mr. E. F. Green	

Page 1 of 3  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4889

CERTIFICATE OF DEATH

04839

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Hook</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Hook</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>TILGHMAN AUGUSTUS HOLDER</b>		4. DATE OF DEATH Month Day Year <b>April 23, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 9, 1882</b>
9. AGE (In years last birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Receiving Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Brownsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Holder</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth Phillips</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>705-05-7773</b>	
17. INFORMANT <b>Mr. Edwin Holder</b>		Address <b>RFD # 1, Knoxville, Md., Box 620</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1954</b> , 19____, to <b>1959</b> , 19____, that I last saw the deceased alive on <b>3/24</b> , 19 <b>59</b> , and that death occurred at <b>5:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Marion Wilbourn</b> M.D. <b>Charles Town, W. Va.</b> PHYSICIAN'S NAME (Type) <b>DR. MILDRED WILLIAMS</b> <b>CHARLES TOWN, W. VA.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/26/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>
22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 27 '59</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Donald Eakles</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Howard</b>	







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04840

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	c. LENGTH OF STAY IN 1b <b>50 yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>7 Moller Ave.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>KENNETH</b> Last <b>HOUP</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 3, 1893</b>
9. AGE (in years last birthday) <b>65 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dust Collecting</b>	
11. BIRTHPLACE (State or foreign country) <b>Boonesboro, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph H. Houpt</b>		14. MOTHER'S MAIDEN NAME <b>Annie G. Palmer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-09-5792</b>	
17. INFORMANT <b>Mrs. Harry K. Houpt</b>		Address <b>7 Moller Ave. Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary thrombosis</b> <b>420.1</b> DUE TO <b>Arteriosclerotic coronary heart disease</b> Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>XXXX</b> none 19 <b>11:00 AM XXXX</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	20f. (City or town) (County) (State) <b>- - -</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>S. Robert Wells</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/8/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 9 '59</b>	
ADDRESS <b>Wm. G. Host v. Bus.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hana</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or reinterment, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4890

Item 9 Film G241 4-27-59 et

## CERTIFICATE OF DEATH

04841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Ringgold</b>			c. LENGTH OF STAY IN 1b <b>56 Years</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Smithsburg #2</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Nora</b> Middle <b>E.</b> Last <b>Huff</b>			4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/14/1883</b>		9. AGE (In years last birthday) <b>75 7/6</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Smithsburg Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>George Noford</b>			14. MOTHER'S MAIDEN NAME <b>Clarine Brightwiser</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Walter L. Huff, Smithsburg Md., #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arterioscleriosis</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>  <b>5 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>9-13-59</b> , 19____, to <b>4-19-59</b> , 19____, that I last saw the deceased alive on <b>4-19-59</b> , 19____, and that death occurred at <b>2:25 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Smithsburg, Md.</b> DATE SIGNED <b>4-21-59</b>					
ACTUAL SIGNATURE <b>Charles E. Hess</b>		M.D. <b>Smithsburg, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Charles E. Hess, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/22/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ringgold</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg #2, Washington Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter L. Huff</b>		ADDRESS <b>Waynesboro Pa</b>		24a. REC'D BY REGISTRAR <b>APR 22 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>



4843

## CERTIFICATE OF DEATH

04842

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BREATHERSVILLE RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MARYLAND STATE HOSPITAL</u>				d. STREET ADDRESS <u>BOONSBORO MD. R. 1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY - LEO - JONES</u>				4. DATE OF DEATH Month Day Year <u>APRIL 3 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 6. 1881</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM WORK</u>		11. BIRTHPLACE (State or foreign country) <u>KEDYSVILLE WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN H. JONES</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. MCNAMEE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yet, no, or unknown)		16. SOCIAL SECURITY NO. <u>217-30-5897A</u>		17. INFORMANT <u>LLOYD BITNER</u>		Address <u>BOONSBORO MD. R. 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>154X CONFLUENT LOBULAR PNEUMONIA - BILATERAL</u> 9 days DUE TO: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF RECTUM WITH GENERALIZED METASTASIS</u> 4 YEARS DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BILATERAL HYDRONEPHROSIS</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>NOV. 24</u> , 19 <u>58</u> , to <u>APRIL 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>APRIL 3</u> , 19 <u>59</u> , and that death occurred at <u>9:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Evaristo R. Laddizabal</u> M.D.				ADDRESS (Street, city or town, state) <u>1500 PRUNGSGLAVIA AVE</u> DATE SIGNED <u>4-3-59</u>			
PHYSICIAN'S NAME (Type) <u>Evaristo R. Laddizabal Hagerstown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 5, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MANOR CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NR. TILGHMAN TOWN WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Radt</u> ADDRESS <u>Boonsboro Md</u>				24a. REC'D BY REGISTRAR DATE <u>APR 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Frazier</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







## CERTIFICATE OF DEATH

04843  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>34YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>253 S. MULBERRY ST.</b>		e. STREET ADDRESS <b>1253 S. MULBERRY ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>MILDRED</b> Middle <b>ORPHA</b> Last <b>JORDAN</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8/15/1912</b>
9. AGE (In years last birthday) <b>46 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHOE DRESSER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHOE MFG. CO.</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>FLOYD W. GRIFFITH</b>	
14. MOTHER'S MAIDEN NAME <b>FLORA MAE LEWIS</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>220-16-0123</b>		17. INFORMANT <b>MR. FLOYD W. GRIFFITH</b> Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY INVOLVEMENT</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CANCER WITH GENERALIZED METASTASIS.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>APP. 6 MO.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4 DEC.</b> , 19 <b>58</b> , to <b>18 APR.</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>18 APR.</b> , 19 <b>59</b> , and that death occurred at <b>2:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>251 E. Baltimore St.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Hugo A. Sacchet</b> M.D. <b>251 E. Baltimore St.</b>			
PHYSICIAN'S NAME (Type) <b>Hugo A. Sacchet, M. D.</b> <b>Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/24/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment</b>		24a. REC'D BY REGISTRAR <b>DATE APR 24 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4845  
CERTIFICATE OF DEATH

04844

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>45 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>21 E. BALTIMORE ST.</b>				d. STREET ADDRESS <b>21 E. BALTIMORE ST.</b>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>DEE</b> Last <b>JUDD</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>3</b> Year <b>19 59</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/11/1890</b>	9. AGE (In years last birthday) <b>68 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED ELECTRICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CITY LIGHT PLANT</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN S. JUDD</b>				14. MOTHER'S MAIDEN NAME <b>MOLLIE A. JUDD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-09-7758</b>		17. INFORMANT <b>MRS. MARYETTA McCORMICK</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerotic heart disease</b> DUE TO (c) <b>2 year</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>1 Jan</b> , 19 <b>57</b> , to <b>3 April</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1 April</b> , 19 <b>59</b> , and that death occurred at <b>5:45 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. Eldon G. Hoachlander</b>			ADDRESS (Street, city or town, state) <b>115 W. Wash. St.</b>		DATE SIGNED <b>April 4 '59</b>		
PHYSICIAN'S NAME (Type) <b>Eldon G. Hoachlander</b>			<b>Hagerstown Md.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/5/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BEAHMS CHAPEL CEM.</b>	22d. LOCATION (City, town, or county) <b>LURAY VA.</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. T. Korman</b>			ADDRESS <b>Hagerstown Md.</b>		24a. REC'D. BY REGISTRAR DATE <b>APR '8 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN A. BROWN		AGE 45		SEX Male		RACE White		DATE OF DEATH 10/15/1918		PLACE OF DEATH Home	
RESIDENCE 1234 Main St., Baltimore, Md.		OCCUPATION Carpenter		EDUCATION High School		MARRIAGE Married		CAUSE OF DEATH Pneumonia		MANNER OF DEATH Natural	
BIRTH 10/15/1873		PLACE OF BIRTH Maryland		PARENTS John A. Brown, Mary A. Brown		SPOUSE Mary A. Brown		CHILDREN None		GRANDCHILDREN None	
DATE OF BIRTH 10/15/1873		PLACE OF BIRTH Maryland		PARENTS John A. Brown, Mary A. Brown		SPOUSE Mary A. Brown		CHILDREN None		GRANDCHILDREN None	
DATE OF DEATH 10/15/1918		PLACE OF DEATH Home		CAUSE OF DEATH Pneumonia		MANNER OF DEATH Natural		CERTIFICATE NO. 12345		REGISTERED	

vertical column title

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4846

## CERTIFICATE OF DEATH

Reg. Dist. No. 04845

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>				d. STREET ADDRESS <b>Route # 1.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>EMORY KELBAUGH</b>				4. DATE OF DEATH Month Day Year <b>April 1 1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 1, 1870</b>		9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Gen. Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Kelbaugh</b>				14. MOTHER'S MAIDEN NAME <b>Mary S.E. Forrest</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>James Smith, Smithsburg, Md. Rt. #1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Toxicemia</b> <b>593x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Kidney function failure</b> DUE TO (c) <b>5 days</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 20</b> , 19 <b>59</b> , to <b>Mar. 30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Mar. 30</b> , 19 <b>59</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Thurmont - Md.</b> DATE SIGNED ACTUAL SIGNATURE <b>James K. Gray</b> M.D. <b>Thurmont - Md.</b> PHYSICIAN'S NAME (Type) <b>James K. Gray</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 4, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Bethel M.E.</b>		22d. LOCATION (City, town, or county) (State) <b>Nr. Garfield Fred. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittle</b> ADDRESS <b>Paul F. Bittle, Myersville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4891

## CERTIFICATE OF DEATH

Reg. Dist. No. 04846

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO RURAL</u>				c. LENGTH OF STAY IN 1b <u>25 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOONSBORO MD. R.2</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FOSTER</u> Middle <u>B</u> Last <u>KEPHART</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY-23-1894</u>		9. AGE (In years last birthday) <u>64</u> yrs.	10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>4</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICAL CONTRASTION- RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FRED. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CARLETON E. KEPHART</u>				14. MOTHER'S MAIDEN NAME <u>WARRENFELTZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>				16. SOCIAL SECURITY NO. <u>218-30-9872</u>		17. INFORMANT <u>CECIL F. KEPHART BOONSBORO MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart D</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>April 7-1959.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>April 7</u> , 19 <u>59</u> , to <u>April 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April</u> , 19 <u>59</u> , and that death occurred at <u>1:30 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Sidney Novenstein</u> M.D. <u>Boonsboro Md</u> PHYSICIAN'S NAME (Type) <u>SIDNEY NOVENSTEIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL-13-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East.</u> ADDRESS <u>BOONSBORO MD</u>				24a. REC'D BY REGISTRAR DATE <u>APR 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
OCCUPATION: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
SIGNATURE OF PHYSICIAN: [illegible]  
SIGNATURE OF REGISTRAR: [illegible]  
DATE OF REGISTRATION: [illegible]

THE REGISTRAR



TO BE FILLED BY THE REGISTRAR  
TO BE FILLED BY THE REGISTRAR  
TO BE FILLED BY THE REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4847

## CERTIFICATE OF DEATH

Reg. Dist. No. 04847

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>18 hours</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>Hagerstown Route #4</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Roscoe</b>		First <b>Paul</b> Middle <b>Keplinger</b> Last		4. DATE OF DEATH <b>April</b>		Month <b>2</b> Day <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 9, 1901</b>		9. AGE (In yrs. last birthday) <b>57</b> yrs. <b>11</b> Months <b>23</b> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>shoe laster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>shoe</b>		11. BIRTHPLACE (State or foreign country) <b>nr. Bakersville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Keplinger</b>				14. MOTHER'S MAIDEN NAME <b>Anna Mull</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT Address <b>Mrs. Ethel G. Keplinger Route #4</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. f. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-1-59</b> , 19____, to <b>4-2-59</b> , 19____, that I last saw the deceased alive on <b>4-1-59</b> , 19____, and that death occurred at <b>5:45A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Smithsburg, Md.</b> DATE SIGNED <b>4-2-59</b> ACTUAL SIGNATURE <b>Charles F. Hess</b> M.D. PHYSICIAN'S NAME (Type) <b>Charles F. Hess, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-4-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Broadfording Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>near Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John W. Minnich</b>				ADDRESS <b>415 Wilson Blvd., East</b>		24a. REC'D BY REGISTRAR <b>APR 6 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>							
Minnich Funeral Home, Hagerstown, Md.							

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES M. HARRIS		SEX Male		AGE 45	
DATE OF DEATH April 1, 1901		PLACE OF DEATH Hagerstown, Md.		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		LOCALITY OF DEATH Hagerstown, Md.		OCCUPATION Farmer	
DATE OF BIRTH April 1, 1901		PLACE OF BIRTH Hagerstown, Md.		EDUCATION None	
MARRIAGE Married		SPOUSE Mary Harris		CHILDREN None	
FATHER'S NAME John Harris		MOTHER'S NAME Mary Harris		FAMILY HISTORY None	
PREVIOUS ILLNESS None		TREATMENT None		POST-MORTEM None	
SIGNATURE OF PHYSICIAN J. M. Harris		SIGNATURE OF WITNESS J. M. Harris		SIGNATURE OF DECEASED J. M. Harris	
DATE OF SIGNATURE April 1, 1901		PLACE OF SIGNATURE Hagerstown, Md.		OCCUPATION Farmer	
FATHER'S NAME John Harris		MOTHER'S NAME Mary Harris		FAMILY HISTORY None	
PREVIOUS ILLNESS None		TREATMENT None		POST-MORTEM None	
SIGNATURE OF PHYSICIAN J. M. Harris		SIGNATURE OF WITNESS J. M. Harris		SIGNATURE OF DECEASED J. M. Harris	
DATE OF SIGNATURE April 1, 1901		PLACE OF SIGNATURE Hagerstown, Md.		OCCUPATION Farmer	

10-500-1000

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04848

4892  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SAN MAR</u>		c. LENGTH OF STAY IN 1b <u>3 WEEKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAHRNEY-KEEDY MEMORIAL HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>KATHERINE - DAISY - KLINE</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 14, 1871</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1-YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>FRED. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANKLIN E. ALEXANDER</u>		14. MOTHER'S MAIDEN NAME <u>LYDIA E. SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>NO.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. MARGARET STERNER</u>		Address <u>BOONSBORO MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Arteriosclerotic Heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>2 weeks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>March 1, 1959</u> to <u>April 7, 1959</u> , that I last saw the deceased alive on <u>April 7, 1959</u> , and that death occurred at <u>10:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. Livan</u>		ADDRESS (Street, city or town, state) <u>Boonsboro</u>	
PHYSICIAN'S NAME (Type) <u>G. W. Livan</u>		DATE SIGNED <u>4/9/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>APR. 10, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>	22d. LOCATION (City, town, or county) _____ (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Bash</u>		ADDRESS <u>Boonsboro Md</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

4928

DATE OF DEATH

PLACE OF DEATH

SEX

AGE

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

REMARKS

SIGNATURE

DATE

PLACE

REMARKS

SIGNATURE

DATE

PLACE

REMARKS

SIGNATURE

DATE

PLACE

REMARKS

SIGNATURE

DATE

PLACE

REMARKS

SIGNATURE

DATE

PLACE



THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A LICENSED NURSE IN THE STATE OF MARYLAND. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR A LICENSED NURSE WHO IS NOT CURRENTLY LICENSED IN THE STATE OF MARYLAND. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR A LICENSED NURSE WHO IS NOT CURRENTLY LICENSED IN THE STATE OF MARYLAND.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G242 5-6-59 et

4893

## CERTIFICATE OF DEATH

04849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WILLIAMSPORT</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WILLIAMSPORT SANITARIUM</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRINGS, Md</b> d. STREET ADDRESS <b>102 LYNNMOORE DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>S.</b> Last <b>KLINE</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 10, 1878</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barbering</b>	
11. BIRTHPLACE (State or foreign country) <b>Mc Keesport, Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DANIEL KLINE</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE ENGLEBRIGHT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Same as #2</b>	
17. MRS. J.C. TERRY (DAUGHTER)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemic</b> DUE TO (b) <b>053.3</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congrenous to e - Paralytic ileus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>AUG 1</b> , 19 <b>59</b> , to <b>April 25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>April 24</b> , 19 <b>59</b> , and that death occurred at <b>7:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Williamsport, Md</b> DATE SIGNED <b>April 28, 1959</b> ACTUAL SIGNATURE <b>Max E. Byrkit</b> M.D. PHYSICIAN'S NAME (Type) <b>Max E. Byrkit, M.D.</b> <b>28 W. Potomac St</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 27, '59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Martinsburg Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert J. Wolf Williamsport, Md</b> ADDRESS		24a. REC'D BY REGISTRAR <b>APR 30 '59</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**4848**

**CERTIFICATE OF DEATH**

**04850**

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>Unk</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>				d. STREET ADDRESS <b>Ijamsville 10X-2</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Charles</b> Last <b>Kolb</b>				4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 Nov 1873</b>	9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Butcher</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Christian Kolb</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Whitman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-7182</b>		INFORMANT Address <b>Mrs. Caroline Suck, Cullen, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1950 CONFLUENT lobular pneumonia, bilateral</b> DUE TO (b) <b>carcinoma of adrenals &amp; metastasis</b> DUE TO (c) <b>to ribs, vertebrae and liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary emphysema</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 4, 1959</b> to <b>April 17, 1959</b> , that I last saw the deceased alive on <b>April 17, 1959</b> , and that death occurred at <b>1:40 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Victor L. Ramos</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>Western Md. State Hospital April 17/59</b>			
PHYSICIAN'S NAME (Type) <b>VICTOR L. RAMOS</b>				<b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-20-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>APR 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

1928

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4843 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
Item 7, Film G241, 4/13/59 fcy

04851

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 Hrs</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Baltimore City</b>		3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1161 Kuhn Ave</b>		d. STREET ADDRESS <b>802 Umbra St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b>		First <b>GEORGE</b>		Middle <b>KRAMER</b>		Last <b>Sr</b>		4. DATE OF DEATH <b>April 2 1959</b>		Month <b>19</b>		Day <b>19</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>Jan'y 26 1910</b>		9. AGE (In years last birthday) <b>49 yrs.</b>		IF UNDER 1 YEAR Months <b>49</b>		IF UNDER 24 HRS. Days <b>49</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Freight Solicitor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking Co</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore City Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Harry Kramer</b>						14. MOTHER'S MAIDEN NAME <b>Belle (No Record)</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>William G. Kramer Jr</b>				Address <b>802 Umbra St Baltimore City Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> <b>420.1</b> DUE TO <b>Arteriosclerotic coronary heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH													
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>None</b> 19 p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) <b>-</b>		(County) <b>-</b>		(State) <b>-</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>4-3-59</b>					
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>4/7/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Baltimore County Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>						ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>APR 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

FOR STATE  
HEALTH DEPT.



THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A NURSE REGISTERED IN THE STATE OF MARYLAND. IT IS VOID IF SIGNED BY ANY OTHER PERSON.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
1922 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIED		SINGLE		WIDOWED		DIVORCED		SEPARATED		OTHER	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA	
SIGNATURE OF PHYSICIAN		SIGNATURE OF NURSE		SIGNATURE OF EXAMINER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF RECORDS		SIGNATURE OF VITALS		SIGNATURE OF HEALTH		SIGNATURE OF DEATH		SIGNATURE OF STATE	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		CAUSE OF EXAMINATION		MANNER OF EXAMINATION		DISEASE		SYMPTOMS		TREATMENT		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA	
SIGNATURE OF PHYSICIAN		SIGNATURE OF NURSE		SIGNATURE OF EXAMINER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF RECORDS		SIGNATURE OF VITALS		SIGNATURE OF HEALTH		SIGNATURE OF DEATH		SIGNATURE OF STATE	

4850

## CERTIFICATE OF DEATH

04852

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN lb <b>10 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1546 Dual Highway</b>				d. STREET ADDRESS <b>1546 Dual Highway</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Harvey</b> Middle <b>Evers</b> Last <b>Krebs</b>				4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 16 1869</b>		9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>0</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Owner Ret'd</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>St. James Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>George Krebs</b>				14. MOTHER'S MAIDEN NAME <b>Tracy Easterday</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		INFORMANT <b>Mrs. Earl Dinsmore</b> Address <b>1546 Dual Highway Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>420.0</b> DUE TO <b>Atherosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>virus infection</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>year.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/14</b> , 19 <b>59</b> , to <b>4/16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4/16</b> , 19 <b>59</b> , and that death occurred at <b>7:35 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>135 No. Potomac St</b> DATE SIGNED <b>4/17/59</b> ACTUAL SIGNATURE <b>S. J. Bayler</b> M.D. PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 19-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Williamsport Md</b>				24a. REC'D BY REGISTRAR DATE <b>APR 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 22d Film G242 5-6-59 et  
4894  
CERTIFICATE OF DEATH

04853

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R # 6</u> c. LENGTH OF STAY IN 1b <u>18 Yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reid</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hagerstown R # 6</u> d. STREET ADDRESS <u>Reid Lehman's Mill</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ESTHER</u> First <u>HEEFNER</u> Middle <u>LEHMAN</u> Last		4. DATE OF DEATH <u>April 22 1959</u> Month <u>19</u> Day <u>19</u> Year	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jany 29 1895</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Heefner</u>		14. MOTHER'S MAIDEN NAME <u>Effie Sprengle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-34-0792</u>	
17. INFORMANT <u>Lester H. Lehman Sr</u>		Address <u>Hagerstown Md. R# 6</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 Nov.</u> , 19 <u>58</u> , to <u>22 April</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>18 April</u> , 19 <u>59</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin J. Hoachlander</u>		ADDRESS (Street, city or town, state) <u>115 W. Washington</u>	
PHYSICIAN'S NAME (Type) <u>Edwin J. Hoachlander</u>		DATE SIGNED <u>4/24/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-26-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew L. Hoffman, Hagerstown, Md.</u>		24a. RECEIVED BY REGISTRAR <u>APR 28 1959</u>	
ADDRESS <u>Hagerstown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. TIME OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH	
11. PLACE OF DEATH		12. DATE OF DEATH		13. TIME OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH	
16. PLACE OF DEATH		17. DATE OF DEATH		18. TIME OF DEATH		19. CAUSE OF DEATH		20. MANNER OF DEATH	
21. PLACE OF DEATH		22. DATE OF DEATH		23. TIME OF DEATH		24. CAUSE OF DEATH		25. MANNER OF DEATH	
26. PLACE OF DEATH		27. DATE OF DEATH		28. TIME OF DEATH		29. CAUSE OF DEATH		30. MANNER OF DEATH	
31. PLACE OF DEATH		32. DATE OF DEATH		33. TIME OF DEATH		34. CAUSE OF DEATH		35. MANNER OF DEATH	
36. PLACE OF DEATH		37. DATE OF DEATH		38. TIME OF DEATH		39. CAUSE OF DEATH		40. MANNER OF DEATH	
41. PLACE OF DEATH		42. DATE OF DEATH		43. TIME OF DEATH		44. CAUSE OF DEATH		45. MANNER OF DEATH	
46. PLACE OF DEATH		47. DATE OF DEATH		48. TIME OF DEATH		49. CAUSE OF DEATH		50. MANNER OF DEATH	
51. PLACE OF DEATH		52. DATE OF DEATH		53. TIME OF DEATH		54. CAUSE OF DEATH		55. MANNER OF DEATH	
56. PLACE OF DEATH		57. DATE OF DEATH		58. TIME OF DEATH		59. CAUSE OF DEATH		60. MANNER OF DEATH	
61. PLACE OF DEATH		62. DATE OF DEATH		63. TIME OF DEATH		64. CAUSE OF DEATH		65. MANNER OF DEATH	
66. PLACE OF DEATH		67. DATE OF DEATH		68. TIME OF DEATH		69. CAUSE OF DEATH		70. MANNER OF DEATH	
71. PLACE OF DEATH		72. DATE OF DEATH		73. TIME OF DEATH		74. CAUSE OF DEATH		75. MANNER OF DEATH	
76. PLACE OF DEATH		77. DATE OF DEATH		78. TIME OF DEATH		79. CAUSE OF DEATH		80. MANNER OF DEATH	
81. PLACE OF DEATH		82. DATE OF DEATH		83. TIME OF DEATH		84. CAUSE OF DEATH		85. MANNER OF DEATH	
86. PLACE OF DEATH		87. DATE OF DEATH		88. TIME OF DEATH		89. CAUSE OF DEATH		90. MANNER OF DEATH	
91. PLACE OF DEATH		92. DATE OF DEATH		93. TIME OF DEATH		94. CAUSE OF DEATH		95. MANNER OF DEATH	
96. PLACE OF DEATH		97. DATE OF DEATH		98. TIME OF DEATH		99. CAUSE OF DEATH		100. MANNER OF DEATH	

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. RACE  
5. OCCUPATION  
6. PLACE OF BIRTH  
7. DATE OF BIRTH  
8. TIME OF DEATH  
9. CAUSE OF DEATH  
10. MANNER OF DEATH  
11. PLACE OF DEATH  
12. DATE OF DEATH  
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90. MANNER OF DEATH  
91. PLACE OF DEATH  
92. DATE OF DEATH  
93. TIME OF DEATH  
94. CAUSE OF DEATH  
95. MANNER OF DEATH  
96. PLACE OF DEATH  
97. DATE OF DEATH  
98. TIME OF DEATH  
99. CAUSE OF DEATH  
100. MANNER OF DEATH



4851

CERTIFICATE OF DEATH

04854

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>WASH.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN lb <b>8 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASH. COUNTY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>LOUISE</b> Last <b>LESHER</b>		4. DATE OF DEATH Month <b>4</b> Day <b>15</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 13, 1914</b>
9. AGE (In years lost birthday) yrs. <b>44</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL S. McCARTY</b>		14. MOTHER'S MAIDEN NAME <b>ALTA MAE MILLS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-09-0943</b>	
17. ADDRESS <b>W. HAROLD LESHER CLEAR SPRING, MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>592 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>CHRONIC GLOMERULONEPHRITIS WITH HYPERTENSION</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b> <b>15 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MARCH 2, 1959</b> to <b>APRIL 15, 19 59</b> , that I last saw the deceased alive on <b>APRIL 15, 19 59</b> , and that death occurred at <b>10:35 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Archie Robert Cohen</i> M.D.		PHYSICIAN'S NAME (Type) <b>ARCHIE ROBERT COHEN, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/18/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>CLEAR SPRING, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Clark</i>		24a. REC'D BY REGISTRAR DATE <b>APR 20 '59</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>			

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

LOUISE LEGER

WITNESSES

CERTIFICATE OF DEATH, DEPARTMENT OF HEALTH, STATE OF NEW YORK

DEATH

MARCH 2, 1941

AT

STATE OF NEW YORK, DEPARTMENT OF HEALTH

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4895

CERTIFICATE OF DEATH

04855

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CLEAR SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL CLEAR SPRING, MD RT. 1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RESIDENCE</b>		d. STREET ADDRESS <b>NONE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELMER</b> Middle <b>A</b> Last <b>LESHER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 13, 1889</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>4</b> Hours <b>4</b> Min. <b>4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	
11. BIRTHPLACE (State or foreign country) <b>CLEAR SPRING DISTRICT</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ISSAC LESHER</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE TICE LESHER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WORLD WAR I</b>		16. SOCIAL SECURITY NO. <b>217-09-9585</b>	
17. INFORMANT <b>ELZIE LESHER</b>		Address <b>CLEAR SPRING, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Acute Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO <b>Sudden</b> (c) <b>Sudden</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 3, 1959</b> to <b>April 5, 1959</b> , that I last saw the deceased alive on <b>April 3, 1959</b> , and that death occurred at <b>11:00</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David R. Brewer</b> M.D.		DATE SIGNED <b>3/6/59</b>	
PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>		ADDRESS (Street, city or town, state) <b>Clear Spring Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>APRIL 7, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ST. PAULS CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>CLEAR SPRING, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Clark</b> ADDRESS <b>CLEAR SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>DATE APR 9 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hunt</b>

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081  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal of the body.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4852 CERTIFICATE OF DEATH

04856

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>11 Wks</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>Moller Apts</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>LENA</b> Middle <b>LOTTIE</b> Last <b>LYON</b>		4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1959</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 12 1879</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William Plotter</b>			14. MOTHER'S MAIDEN NAME <b>Rose Kursh</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-----</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Dr. I. B. Lyon</b> Address <b>1500 Penna Ave</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterial embolus, left leg</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hagerstown Md.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>46 hours -</b> <b>About 10 years -</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3/5</b> , 19 <b>45</b> , to <b>4-14</b> , 19 <b>49</b> , that I last saw the deceased alive on <b>4-14</b> , 19 <b>49</b> , and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>John H. Hornbaker</b> M.D. <b>154 West Washington Street</b> <b>4:15:59</b> PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b> <b>Hagerstown, Md.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/16/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>B'Nai Abraham Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b> ADDRESS <b>Hagerstown Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Krasik</b>





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4853 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
Item 9, Film G241, 4/17/59 fcy

04857

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY in 1b <u>1 Hr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>130 E. Baltimore Street</u>			d. STREET ADDRESS <u>130 E. Baltimore Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>RALPH PAGE MARPEL</u>			4. DATE OF DEATH Month Day Year <u>April 6 1959 19</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 17 1901</u>		9. AGE (In years last birthday) <u>57</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Makes Blue Prints</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Arthur H. Marpel</u>			14. MOTHER'S MAIDEN NAME <u>Camilla Everhart</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Mrs Jane W. Marpel 130 E. Baltimore St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot into skull and brain (32 calibre revolver)</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>976X</u> DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in head</u>		
20c. TIME OF INJURY Month, Day, Year Hour <u>12:30</u> p. m. <u>Apr/ 6 1959</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>in car</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>S. Robert Wells</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>			24a. REC'D BY REGISTRAR <u>APR 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hawk</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4854

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04858  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>35 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HARRY EDWIN MARTIN</b>		4. DATE OF DEATH <b>April 3 19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 28, 1874</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Emmitsburg, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>John David Martin</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Hann</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-30-9611</b>	
17. INFORMANT <b>Mrs. Ethel Martin</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull with intra-cranial hemorrhage</b> DUE TO <b>812X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>33 days</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian crossing street that was struck by automobile</b>	
20c. TIME OF INJURY Month, Day, Year <b>12:40 p. m. Feb. 28 1959</b>		20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) <b>Hagerstown</b> (County) <b>Wash</b> (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4-6-59</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/7/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Franklin Rouzer</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
1552 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1552  
1552

Name of Deceased		John David Smith	
Age		32 days	
Sex		Male	
Race		White	
Date of Death		September 2, 1914	
Place of Death		Home, Baltimore, Maryland	
Cause of Death		Infantile Spasms	
Disease or Injury		No disease or injury	
Signature of Medical Examiner		[Signature]	
Signature of Physician		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	
Signature of Burial Officer		[Signature]	
Signature of Undertaker		[Signature]	
Signature of Witness		[Signature]	
Signature of Deceased		[Signature]	
Signature of Family		[Signature]	
Signature of Neighbor		[Signature]	
Signature of Minister		[Signature]	
Signature of Priest		[Signature]	
Signature of Rabbi		[Signature]	
Signature of Imam		[Signature]	
Signature of Other		[Signature]	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4855

## CERTIFICATE OF DEATH

Reg. Dist. No.

04859  
302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND-		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>12 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>382 S. Cleveland Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>KAWANEE</b>		First <b>PAGE</b>		Middle <b>MAYES</b>		Last	
4. DATE OF DEATH <b>April</b>		Month <b>21</b>		Day <b>19</b>		Year <b>59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 20, 1959</b>		9. AGE (In years last birthday) yrs. <b>12</b> Months <b>12</b> Days <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Paige Mayes-</b>				14. MOTHER'S MAIDEN NAME <b>Esther Louise Shaffer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Richard R. Mayes</b> Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital heart disease</b> <b>754.5</b> DUE TO <b>No other disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>Birth</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19__		20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>April 20, 1959</b> , to <b>April 21, 1959</b> , that I last saw the deceased alive on <b>April 20, 1959</b> , at <b>8:55 A.</b> , and that death occurred at <b>8:55 A.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert F. Keadle</b>		ADDRESS (Street, city or town, state) <b>Hagerstown, Maryland</b> DATE SIGNED <b>4-22-59</b>					
PHYSICIAN'S NAME (Type) <b>Robert F. Keadle</b>		318 North Potomac Street, Hagerstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/23/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 27 59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2081212XV5







MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4856

CERTIFICATE OF DEATH

04860  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>1 1/2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>Route 3</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edna Senora McCubbin</b> First Middle Last				4. DATE OF DEATH <b>April 3</b> Month Day Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 21, 1885</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Westminster Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Jessie Livingston</b>				14. MOTHER'S MAIDEN NAME <b>Frances V. Spurrier</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Mrs. Ethel Small Hag. Rt. 3</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>5 yrs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>JAN.</b> , 19 <b>58</b> , to <b>APRIL</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4-3</b> , 19 <b>59</b> , and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>302 N. Potomac St.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>John D. Turco</b> M.D.							
PHYSICIAN'S NAME (Type) <b>John Turco</b>				<b>Hagerstown Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-6-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Scott F. Minnich &amp; Son Hagerstown Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	



## CERTIFICATE OF DEATH

04861

Reg. Dist. No. 302

4857

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN TB <b>5 mo. 13 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlock Nursing Home</b>		d. STREET ADDRESS <b>11 West Antietam Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELVA</b> Middle <b>GRACE</b> Last <b>MIDDLEKAUFF</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 14, 1866</b>
9. AGE (In years last birthday) <b>92</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>	11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Joseph A. Middlekauff</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>214-14-6676A</b>	
17. INFORMANT <b>LeRoy Heard</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-vascular Disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>November, 1958</b> to <b>April 13, 1959</b> , that I last saw the deceased alive on <b>April 11th</b> , 1959, and that death occurred at <b>3:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>138 W. Washington St.</b> DATE SIGNED ACTUAL SIGNATURE <b>Ernest F. Poole</b> M.D. PHYSICIAN'S NAME (Type) <b>Ernest F. Poole M. D.</b> <b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/15/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> <b>R. Suter-Rouzer</b>		ADDRESS <b>Hagerstown, Md.</b>	24a. REC'D BY REGISTRAR <b>APR 16 '59</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1900-1901

1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

1997-1998

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4858  
CERTIFICATE OF DEATH

04862  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>9 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOSIAH RAY MITCHELL</u>		4. DATE OF DEATH <u>APRIL 20 - 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 9, 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	
11. BIRTHPLACE (State or foreign country) <u>ZITTESTOWN WASH. Co. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE MITCHELL</u>		14. MOTHER'S MAIDEN NAME <u>ANN ZITTLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-36-7218</u>	
17. INFORMANT <u>MRS. ETHEL MITCHELL</u>		Address <u>BOONSBORO MD. R. 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio-sclerotic heart D</u> <u>420.0</u> -DUE TO- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Recent Coronary Thrombosis</u> DOE TO (c) <u>Aneurysm of descending aorta</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>Jan 11 - 1959</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decomposition of tissues</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 11</u> , 19 <u>59</u> , to <u>April 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 20</u> , 19 <u>59</u> , and that death occurred at <u>8:35 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sidney Novestine</u> M.D.		ADDRESS (Street, city or town, state) <u>Hagerstown Md</u> DATE SIGNED <u>4-22-59</u>	
PHYSICIAN'S NAME (Type) <u>SIDNEY NOVESTINE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 24 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bart</u>		ADDRESS <u>BOONSBORO MD.</u>	
24a. REC'D BY REGISTRAR <u>APR 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>	



CERTIFICATE OF DEATH

11-1-19

11-1-19

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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4896

## CERTIFICATE OF DEATH

04863

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>				c. LENGTH OF STAY in 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SOUTH MAIN ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>PEARL AGNES MORGAN</u>				4. DATE OF DEATH Month Day Year <u>APRIL 5 1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT-7-1877</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>LITTLESTOWN WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEWIS JONES</u>				14. MOTHER'S MAIDEN NAME <u>MARY KAUFFMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>JOHN F. MORGAN</u> Address <u>BOONSBORO MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>April 2</u> , 19 <u>59</u> , to <u>April 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 2</u> , 19 <u>59</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>4/6/59</u> ACTUAL SIGNATURE <u>G. W. Hevan</u> M.D. <u>Boonsboro Md</u> PHYSICIAN'S NAME (Type) <u>G. W. Hevan</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR. 8 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u> ADDRESS <u>Boonsboro Md</u>				24a. REC'D BY REGISTRAR <u>DATE APR 16 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hunt</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4859 CERTIFICATE OF DEATH

04864  
302  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> COUNTY <u>Fulton</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>3 Mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Martin Manor Nursing Home</u>		d. STREET ADDRESS -----	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>OLIVE</u> Middle <u>PEARL</u> Last <u>MOUSE</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1959</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 20 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Fulton County Pa,</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Vantz</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Shaw</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>22030-8876</u>	
17. INFORMANT <u>William T. Mouse</u>		Address <u>801 Rolling Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>10 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/8</u> , 19 <u>54</u> , to <u>4/4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/4</u> , 19 <u>59</u> , and that death occurred at <u>12:45</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. J. Boyer</u> M.D.		DATE SIGNED <u>4/6/59</u>	
PHYSICIAN'S NAME (Type) <u>D. J. Boyer</u>		<u>135 No Potomac St</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/7/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		24a. REC'D BY REGISTRAR DATE <u>APR 8 '59</u>	
ADDRESS <u>Hagerstown /Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hand</u>	

CERTIFICATE OF DEATH

252

REG. NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

PLACE OF BIRTH

EDUCATION

RELIGION

INDUSTRY

MARRIAGE

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

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JAN 10 1918  
BALTIMORE  
M.D.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

04865

Reg. Dist. No.

4860

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN b <b>13 YEARS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2221 PENNSYLVANIA AVE.</b>		d. STREET ADDRESS <b>2221 PENNSYLVANIA AVE.</b>			
3. NAME OF DECEASED (Type or print) <b>CLEMMIE MAY MULLENDORE</b>		4. DATE OF DEATH Month <b>APRIL</b> - Day <b>9</b> - Year <b>1959</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE-28-1876</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>NR. BOONSBORO WASH. Co. MD. U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN H. HUTZELL</b>		14. MOTHER'S MAIDEN NAME <b>LAURA STEVENS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>2221 PENN AVE. HAGERSTOWN MD.</b> <b>NORMAN B. MULLENDORE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic cardiovascular disease</b> <b>422.1 DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>dissecting</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 yrs.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that I attended the deceased from <b>9/1/59</b> , 19___, to <b>4/9/59</b> , 19___, that I last saw the deceased alive on <b>4/8/59</b> , 19___, and that death occurred at <b>1:00 A.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>W.C. Brewer</b>		M.D. <b>Greenacres, Pa.</b>		DATE SIGNED <b>4/11/59</b>	
PHYSICIAN'S NAME (Type) <b>W.C. Brewer, M.D.</b>		ADDRESS <b>Greenacres, Pa.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>APRIL-12-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROCKERSVILLE CEMETERY</b>	
22d. LOCATION (City, town, or county) (State) <b>ROCKERSVILLE WASH. Co. MD</b>		24a. REQ'D BY REGISTRAR DATE <b>APR 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Best</b>		ADDRESS <b>BOONSBORO MD.</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. W. M. G. BREWSTER  
GREENACRES, PA.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1980

FILE NO.

DATE OF DEATH

PLACE

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

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EDUCATION

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RAIMOND

1

MASTERS COMPANY, 201 E. BALTIMORE ST., BALTIMORE, MD 21201



## CERTIFICATE OF DEATH

04866

Reg. Dist. No.

4861

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>MAY</u> Last <u>MUNDEY</u>				4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 6, 1876</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Henry Moore</u>				14. MOTHER'S MAIDEN NAME <u>Martha Susan Myers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Mrs. W. E. Holland Summit &amp; Surrey Ave.</u>			
17. INFORMANT <u>Mrs. W. E. Holland</u>				Address <u>Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>unknown</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 mins.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 2</u> , 19 <u>59</u> , to <u>April 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 8</u> , 19 <u>59</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>100 Professional Arts Bldg.</u> DATE SIGNED <u>4/10/59</u>							
ACTUAL SIGNATURE <u>William T. Layman, M.D.</u>				M.D. <u>100 Professional Arts Bldg.</u> DATE SIGNED <u>4/10/59</u>			
PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>				<u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 13 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Wm. A. Hunt C. P. Hunt



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4862

## CERTIFICATE OF DEATH

04867

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN b <b>33 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlock Memorial Convalescent Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown,</b> d. STREET ADDRESS <b>1082 Marshall Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bertie</b> Middle <b>Roseanna</b> Last <b>Nogle</b>				4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 13, 1874</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Samuel Six</b>				14. MOTHER'S MAIDEN NAME <b>Lucrettia Staley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Bessie Carbaugh 1082 Marshall St. Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intraabdominal &amp; vertebral metastases</b> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of sigmoid</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic &amp; hypertensive cardiovascular disease</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>1959</b> Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>August 56</b> to <b>April 22 59</b> , that I last saw the deceased alive on <b>April 22 59</b> , and that death occurred at <b>5:50a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>100 Professional Arts Bldg., Hagerstown, Maryland</b> DATE SIGNED <b>4/23/59</b> ACTUAL SIGNATURE <b>W. T. Layman</b> M.D. PHYSICIAN'S NAME (Type) <b>William T. Layman, M. D.,</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>4-26-59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Greager</b> ADDRESS <b>Thurmont, Md.</b> 24a. REC'D BY REGISTRAR DATE <b>APR 28 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>							

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

11387

1882

NAME OF DECEASED JAMES M. JONES		AGE 35		SEX Male		RACE White		DATE OF BIRTH Jan 15, 1847		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE Married		EDUCATION Common		OCCUPATION Clerk		RELIGION Methodist		MANNER OF DEATH Natural		CAUSE OF DEATH Dropsy of the heart	
DATE OF DEATH Jan 25, 1882		PLACE OF DEATH Baltimore, Md.		TIME OF DEATH 10:30 AM		TEMPERATURE 101.0		PULSE 110		RESPIRATION 24	
SIGNATURE OF PHYSICIAN J. M. Jones		SIGNATURE OF WITNESSES J. M. Jones, J. M. Jones		SIGNATURE OF DECEASED J. M. Jones		SIGNATURE OF NEAREST RELATIVE J. M. Jones		SIGNATURE OF CLERK J. M. Jones		SIGNATURE OF REGISTRAR J. M. Jones	
DATE OF REGISTRATION Jan 26, 1882		PLACE OF REGISTRATION Baltimore, Md.		TIME OF REGISTRATION 10:30 AM		TEMPERATURE 101.0		PULSE 110		RESPIRATION 24	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4897 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04868

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X R # 5 Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Smithsburg, Maryland</u>		d. STREET ADDRESS <u>R # 5</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Merle Edward Overcash</u>	4. DATE OF DEATH Month Day Year <u>April 19 19 59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10/4/1914</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Mason</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Rouzeville Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Overcash</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Rowe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes World War 2</u>		16. SOCIAL SECURITY NO. <u>218-01-8826</u>	17. INFORMANT <u>Ivan Overcash, Chambersburg Pa., #5</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide poisoning</u> <u>9773.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Connected exhaust pipe to interior of car</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> p. m. <u>Apr. 19 1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Reservoir property</u>	20f. (City or town) (County) (State) <u>Rural Smithsburg Wash Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, MD.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Harbaugh's</u>
22d. LOCATION (City, town, or county) (State) <u>Smithsburg #2, Franklin Pa.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Grove, Waynesboro Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 27 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

2





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4868 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04869

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b> c. LENGTH OF STAY IN 1b <b>12 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Foundry St.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown Md.</b> d. STREET ADDRESS <b>46 S. Mulberry Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>John</b> Middle <b>Franklin</b> Last <b>Rhodes</b>				<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>29</b> Year <b>19 59</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Nov. 7 1891</b>		<b>9. AGE</b> (In years last birthday) <b>67</b> yrs. IF UNDER 1 YEAR: Months <b>5</b> Days <b>21</b> IF UNDER 24 HRS.: Hours <b></b> Min. <b></b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Labor</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Building Contractor</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A</b>	
<b>13. FATHER'S NAME</b> <b>John L. Rhodes</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Elizabeth Godsard</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>216 05 6289</b>		<b>17. INFORMANT</b> Address <b>Mr. Clinton Rhodes Williamsport Md.</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic coronary heart disease</b> <b>420.1</b> DUE TO <b>Acute coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost, DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.</b> <b>none</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>-none</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <b>none</b> 19 p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>none</b>		<b>20f. (City or town)</b> <b>-</b>		(County) <b>-</b> (State) <b>0</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
<b>ACTUAL SIGNATURE</b> <i>S. Robert Wells</i>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b>	
<b>EXAMINER'S NAME (Type)</b> <b>S. Robert Wells, M.D.</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>May 2-59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Riverview Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> <b>Williamsport Maryland</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Albert L. Leaf Williamsport, Md</i>				<b>ADDRESS</b> <b>Williamsport, Md</b>		<b>24a. REC'D BY REGISTRAR</b> <b>MAY 4 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Hays</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



4864

CERTIFICATE OF DEATH

04870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>62 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>213 Summer St</b>		e. STREET ADDRESS <b>213 Summer St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Fannie</b> Middle <b>Roseanna</b> Last <b>Rice</b>		4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 20, 1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Near Winchester Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James M Lamp</b>		14. MOTHER'S MAIDEN NAME <b>Mary Bailey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>214-09-2583</b>	
17. INFORMANT <b>Mrs. Margaret L. Wiles</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 15, 1946</b> , to <b>Apr 5, 1959</b> , that I last saw the deceased alive on <b>Apr 5, 1959</b> , and that death occurred at <b>137 West Washington St.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert P. Conrad</b>		ADDRESS (Street, city or town, state) <b>137 West Washington St. Hagerstown Md.</b>	
PHYSICIAN'S NAME (Type) <b>Robert P. Conrad</b>		DATE SIGNED <b>4-6-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-7-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hane</b>	

CERTIFICATE OF DEATH

1966

DEATH OF <b>James A. Lamm</b> Date of Death <b>July 20, 1966</b> Place of Death <b>Home</b>		DEATH OF <b>James A. Lamm</b> Date of Death <b>July 20, 1966</b> Place of Death <b>Home</b>	
Name of Deceased <b>James A. Lamm</b> Sex <b>Male</b> Race <b>White</b> Date of Birth <b>July 20, 1884</b> Place of Birth <b>U. S. A.</b>		Name of Deceased <b>James A. Lamm</b> Sex <b>Male</b> Race <b>White</b> Date of Birth <b>July 20, 1884</b> Place of Birth <b>U. S. A.</b>	
Name of Informant <b>Mary Bailey</b> Relationship <b>Wife</b> Address <b>213 Summer St., Hagerstown, Md.</b>		Name of Informant <b>Mary Bailey</b> Relationship <b>Wife</b> Address <b>213 Summer St., Hagerstown, Md.</b>	
Cause of Death <b>Heart Disease</b> Immediate Cause <b>Myocardial Infarction</b> Underlying Cause <b>Coronary Artery Disease</b>		Cause of Death <b>Heart Disease</b> Immediate Cause <b>Myocardial Infarction</b> Underlying Cause <b>Coronary Artery Disease</b>	
Date of Death <b>July 20, 1966</b> Time of Death <b>10:30 AM</b> Place of Death <b>Home</b>		Date of Death <b>July 20, 1966</b> Time of Death <b>10:30 AM</b> Place of Death <b>Home</b>	
Name of Physician <b>Dr. J. H. Lamm</b> Signature <b>[Signature]</b> Address <b>123 Main St., Hagerstown, Md.</b>		Name of Physician <b>Dr. J. H. Lamm</b> Signature <b>[Signature]</b> Address <b>123 Main St., Hagerstown, Md.</b>	
Name of Coroner <b>Robert F. Jones</b> Signature <b>[Signature]</b> Address <b>456 Main St., Hagerstown, Md.</b>		Name of Coroner <b>Robert F. Jones</b> Signature <b>[Signature]</b> Address <b>456 Main St., Hagerstown, Md.</b>	
Name of Registrar <b>Robert F. Jones</b> Signature <b>[Signature]</b> Address <b>456 Main St., Hagerstown, Md.</b>		Name of Registrar <b>Robert F. Jones</b> Signature <b>[Signature]</b> Address <b>456 Main St., Hagerstown, Md.</b>	



4865

## CERTIFICATE OF DEATH

04871

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>58 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>110 Roessner Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>B</b> Last <b>Rickard</b> Sr.		4. DATE OF DEATH Month <b>4</b> Day <b>6</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1, 1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penn. R.R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Luray, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James A. Rickard</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Judd</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>716-03-2077A</b>	
17. INFORMANT <b>Mrs. Grace L. Rickard</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/6/59</b> , 19 <b>59</b> , to <b>4/6/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4/6/59</b> , 19 <b>59</b> , and that death occurred at <b>11:30 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>W. L. Young</b> M.D. <b>4/7/59</b>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>4-9-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		24a. REC'D BY REGISTRAR DATE <b>APR 9 '59</b>	
ADDRESS <b>Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01831

CERTIFICATE OF DEATH

1925

Washington

Death Date

Age at Death

Sex

Color

Place of Birth

Residence at Death

Occupation

Marital Status

Cause of Death

Manner of Death

Signature

Medical Examiner

Physician

County

City

State

*Handwritten signature and notes*

*Large handwritten signature and notes at the bottom of the page*

Death Date

Place of Birth

Residence at Death

Age at Death

Sex

Color

4866

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b>		c. LENGTH OF STAY IN 1b <b>10 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md. 03</b>	
f. STREET ADDRESS <b>328 S. Cleveland Ave.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle Last <b>Shipley</b>		4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 5 1885</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>8</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Downsville Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>Levi Cline</b>		14. MOTHER'S MAIDEN NAME <b>Martha Detrow</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. George Lizer</b>		18. ADDRESS <b>116 W. Potomac St. Williamsport Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Stroke</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b></b> (c) DUE TO <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>May</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/12/59</b> , 19 <b>59</b> , to <b>4/13/59</b> , that I last saw the deceased alive on <b>4/12/59</b> , 19 <b>59</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Albert L. Lizer</b>		DATE SIGNED <b>4/13/59</b>	
PHYSICIAN'S NAME (Type) <b>Albert L. Lizer</b>		M.D. <b>Williamsport Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 15-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Lizer</b>		24a. REC'D BY REGISTRAR DATE <b>APR 16 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1983

CERTIFICATE OF DEATH

1983

Washington

Admission

Admission

Washington

Admission

Admission

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Admission

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Admission

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04873

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Pa. RR &amp; Nursery Rd</u>	c. LENGTH OF STAY IN 1b <u>Transient</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Chambersburg, Pa.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>P.O. 4</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>E</u> Last <u>Shuman</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1929</u>
9. AGE (in years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Route supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Capital Bakery, Inc.</u>	11. BIRTHPLACE (State or foreign country) <u>Penna.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>David J. Shuman</u>	
14. MOTHER'S MAIDEN NAME <u>Alice Reed</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>186-24-7676</u>		17. INFORMANT <u>Mrs. Isabel S. Shuman - P.O. 4, Chambersburg, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull(open)</u> <u>810X</u> DUE TO <u>Multiple fractured Ribs</u> Conditions, if any, which gave rise to immediate cause (b) <u>Fractured femur(left)</u> (a), stating the underlying cause lost. DUE TO (c) <u>Hemorrhage and shock</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driving truck and struck by train at RR crossing</u>	
20c. TIME OF INJURY Month, Day, Year <u>4 to 5 p.m. Apr. 11, 1959</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursery Rd.</u>	20f. (City or town) (County) (State) <u>Hagerstown Wash. Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>April 12 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/14/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas</u>	22d. LOCATION (City, town, or county) (State) <u>St. Thomas, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert P. Barlow</u>		ADDRESS <u>Chambersburg, Pa.</u>	
24a. REC'D BY REGISTRAR <u>APR 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

21

2



6507

118603

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		AGE [REDACTED]		SEX [REDACTED]		RACE [REDACTED]		DATE OF BIRTH [REDACTED]		PLACE OF BIRTH [REDACTED]	
MARRIED [REDACTED]		SINGLE [REDACTED]		WIDOWED [REDACTED]		DIVORCED [REDACTED]		DATE OF MARRIAGE [REDACTED]		PLACE OF MARRIAGE [REDACTED]	
OCCUPATION [REDACTED]		INDUSTRY [REDACTED]		EMPLOYER [REDACTED]		DATE OF EMPLOYMENT [REDACTED]		PLACE OF EMPLOYMENT [REDACTED]		DATE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]		PHYSICAL HISTORY [REDACTED]		SOCIAL HISTORY [REDACTED]		FAMILY HISTORY [REDACTED]	
SIGNATURE OF EXAMINER [REDACTED]		DATE [REDACTED]		PLACE [REDACTED]		TITLE [REDACTED]		COUNTY [REDACTED]		STATE [REDACTED]	

RECEIVED COPY

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

04874  
Reg. Dist. No. 302

4868

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN TB <b>21 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HARRY</b> First <b>LEE</b> Middle <b>SLICK</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 4, 1893</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>	11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William H. Slick</b>	
14. MOTHER'S MAIDEN NAME <b>Emma Florence Stouffer</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>176-05-2599</b>		17. INFORMANT Address <b>Robert K. Slick Hagerstown, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiac Vascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>21 days</b> <b>10 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>Jan 1949</b> 19 to <b>17 Apr 1959</b> , that I lost sows the deceased alive on <b>16 am 1959</b> , and that death occurred at <b>5:10 PM</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>F. F. Lusby</b>		ADDRESS (Street, city or town, state) <b>2301 Potomac St Hagerstown, Md</b> DATE SIGNED <b>18 Apr 59</b>	
PHYSICIAN'S NAME (Type) <b>F. F. Lusby</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/19/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>		24a. REC'D BY REGISTRAR <b>APR 22 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4869

CERTIFICATE OF DEATH

04876

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>5</u> DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON COUNTY HOSPITAL</u>		e. STREET ADDRESS <u>SMITHSBURG MD. R.1</u>	
3. NAME OF DECEASED (Type or print) First <u>TERRY</u> Middle <u>LYNN</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL-2-1959</u>
9. AGE (In years last birthday) yrs. <u>5</u>		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>HAGERSTOWN WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THURMAN SMITH</u>		14. MOTHER'S MAIDEN NAME <u>JERRY SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>THURMAN SMITH</u>		Address <u>SMITHSBURG MD. R.1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> <u>7545</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Onphlocele</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 2</u> , 19 <u>59</u> , to <u>April 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 7</u> , 19 <u>59</u> , and that death occurred at <u>3:45</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>—</u>			
ACTUAL SIGNATURE <u>Sidney Hoverson</u> M.D. <u>—</u>			
PHYSICIAN'S NAME (Type) <u>SIDNEY HOVERSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>APRIL-9-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FAHRNEY'S CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MAPLEVILLE WASH. CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u> ADDRESS <u>Boonsboro Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 16 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4898

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04877

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hancock</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hancock</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>B</u> Last <u>Snyder</u>		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/6/95</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis B. Mann</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Snyder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Guy Benjamin Snyder</u>		Address <u>Hancock R.F.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes m.</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis 1956</u> INTERVAL BETWEEN ONSET AND DEATH <u>1945</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		DATE SIGNED <u>Apr. 13-59</u>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-13-59</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Orchard Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Hancock Wash. Co. md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Howe Hancock md</u>		24a. REC'D BY REGISTRAR <u>APR 15 59</u>	
ADDRESS <u></u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howe</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

item 2 FilmG241 4-27-59 et

4870

## CERTIFICATE OF DEATH

Reg. Dist. No.

04878  
303

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>5 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Palmer Spedden</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14/1875</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meter Reader</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William E. Spedden</b>		14. MOTHER'S MAIDEN NAME <b>Manie S. Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Claude Potterfield</b>		Address <b>415 Va. Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>492X</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>1 wk</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1, 1959</b> to <b>April 13, 1959</b> , that I last saw the deceased alive on <b>April 13, 1959</b> , and that death occurred at <b>9:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Boonsboro, Md. 4/15/59</b> ACTUAL SIGNATURE <b>C. W. H. Van</b> M.D. PHYSICIAN'S NAME (Type) <b>G. W. H. Van</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/15/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		24a. REC'D BY REGISTRAR <b>APR 21 '59</b>	
ADDRESS <b>Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Huns</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		Male		White		April 4, 1968		Memphis, Tennessee	
BIRTH OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
May 19, 1932		May 19, 1932		Memphis, Tennessee		Memphis, Tennessee		Shelby County		Tennessee	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
Married		Married		Memphis, Tennessee		Memphis, Tennessee		Shelby County		Tennessee	
EDUCATION		SCHOOLING		HIGHEST GRADE		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
High School		High School		12		Memphis, Tennessee		Shelby County		Tennessee	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
Minister		Minister		Memphis, Tennessee		Memphis, Tennessee		Shelby County		Tennessee	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH	
Heart Disease		Natural		April 4, 1968		Memphis, Tennessee		Memphis, Tennessee		Shelby County	
DISEASE		SYMPTOMS		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH	
Heart Disease		Chest Pain		April 4, 1968		Memphis, Tennessee		Memphis, Tennessee		Shelby County	
MEDICAL HISTORY		DATE OF MEDICAL HISTORY		PLACE OF MEDICAL HISTORY		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
None		None		None		None		None		None	
SURVIVORS		DATE OF SURVIVORS		PLACE OF SURVIVORS		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
None		None		None		None		None		None	
SIGNATURE OF DECEASED		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
None		None		None		None		None		None	
SIGNATURE OF WITNESS		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
None		None		None		None		None		None	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
None		None		None		None		None		None	
SIGNATURE OF CORONER		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
None		None		None		None		None		None	

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VS A15 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4871

## CERTIFICATE OF DEATH

04879

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>52 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>439 W. Church St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>G</b> Last <b>Spessard</b>		4. DATE OF DEATH Month <b>4</b> Day <b>22</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 26, 1887</b>
9. AGE (In years lost birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>home duties</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Rocky Ridge, Fred. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Gilbert</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Dorsey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
INFORMANT <b>Charles H. Spessard</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 yrs +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1955</b> to <b>22 Apr 1959</b> that I last saw the deceased alive on <b>21 Apr 1959</b> and that death occurred at <b>6:50 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F. F. Lusby</b>		DATE SIGNED <b>22 Apr 59</b>	
PHYSICIAN'S NAME (Type) <b>F. F. Lusby</b>		ADDRESS (Street, city or town, state) <b>2301 Potomac Hagerstown Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>4-25-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Hanks</b>	



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Figure 1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4899

## CERTIFICATE OF DEATH

04880

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CLEAR SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CLEAR SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>ROUTE 40</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HARRY S. SPICKLER</b>		4. DATE OF DEATH Month Day Year <b>4 27 19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 5, 1869</b>
9. AGE (In years lost birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AUTOMOBILE</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEWIS A. SPICKLER</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA P. SHARPLESS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>FRANK A. SPICKLER</b>		Address <b>CLEAR SPRING, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE STOMACH WITH METASTASIS</b> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ANEMIA, DUE TO CHRONIC BLOOD LOSS</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL 22, 1959</b> to <b>APRIL 27, 1959</b> , that I last saw the deceased alive on <b>APRIL 27, 1959</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Archie Robert Cohen</i> M.D.		PHYSICIAN'S NAME (Type) <b>ARCHIE ROBERT COHEN, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/30/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ST. PAULS CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>CLEAR SPRING, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. CLARK</b>		24. REC'D BY REGISTRAR DATE <b>APR 29 '59</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# 1 4900 Items 8,9 FilmG242 5-6-59 et MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

04881

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. LENA RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X MT. LENA RURAL</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOONSBORO MD. R.2</u>		d. STREET ADDRESS <u>BOONSBORO MD. R.2</u>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>CLESSE M STINE</u>		<b>4. DATE OF DEATH</b> Month <u>APRIL</u> Day <u>28</u> Year <u>1959</u>									
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>April 23, 1887</u>								
<b>9. AGE</b> (In years last birthday) <u>72</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS	Months	Days		Hours		Min.		
IF UNDER 1 YEAR	IF UNDER 24 HRS										
Months	Days										
	Hours										
	Min.										
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>LABORER - BUILDING CONTRACTOR</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>BUNKER HILL W.VA. U.S.A.</u>									
<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>									
<b>13. FATHER'S NAME</b> <u>DAVID STINE</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>CLARA BAKER</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>214-09-6314</u>									
<b>17. INFORMANT</b> <u>MRS. GLADYS STINE</u>		<b>Address</b> <u>BOONSBORO MD. R.2</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Essential hypertension</u> DUE TO (c)			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>8 yrs.</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)								
<b>21. I certify that I attended the deceased from</b> <u>April 28, 1959</u> , to <u>April 28, 1959</u> , that I last saw the deceased alive on <u>April 28, 1959</u> , and that death occurred at <u>home</u> M, from the causes and on the date stated above.											
<b>ACTUAL SIGNATURE</b> <u>G. W. Lohan</u> M.D.		<b>ADDRESS</b> (Street, city or town, state) <u>Boonsboro, Md.</u>									
<b>PHYSICIAN'S NAME</b> (Type) <u>G. W. Lohan</u>		<b>DATE SIGNED</b> <u>4/29/59</u>									
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>	<b>22b. DATE THEREOF</b> <u>MAY-1-1959</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>MT. LENA CEMETERY</u>	<b>22d. LOCATION</b> (City, town, or county) (State) <u>MT. LENA WASH. CO. MD.</u>								
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John H. Bass</u>		<b>ADDRESS</b> <u>BOONSBORO MD</u>									
<b>24a. REC'D BY REGISTRAR</b> <u>DATE MAY 4 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and to any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4872

## CERTIFICATE OF DEATH

04882  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PA</u> b. COUNTY <u>FRANKLIN</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENCASTLE</u> 75x3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON CO. HOSPITAL</u>		d. STREET ADDRESS <u>257 So. WASHINGTON</u>	
3. NAME OF DECEASED (Type or print) First <u>IRA</u> Middle <u>O.</u> Last <u>STRITE</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 11 - 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	9. AGE (In years last birthday) <u>85</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Leitersburg md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John A. Strite</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Maun</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Myr May Grace Strite</u>		Address <u>257 S. Washington Greencastle Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RHEUMATIC HEART DISEASE</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>75 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>9/1/39</u> to <u>4/14/59</u> , that I last saw the deceased alive on <u>4/14/59</u> , and that death occurred at <u>12:30 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. C. Braver, M.D.</u>		DATE SIGNED <u>4/14/59</u>	
PHYSICIAN'S NAME (Type) <u>W. C. Braver, M.D.</u>		<u>Greencastle Pa.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	22b. DATE THEREOF <u>4/17/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>near Greencastle Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cond E. N. Minich</u>		24a. REC'D BY REGISTRAR <u>Greencastle Pa</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. King</u>		DATE <u>APR 16 '59</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/55

County of <u>Washington</u> State of <u>MARYLAND</u> DEPARTMENT OF HEALTH—BALTIMORE, 18									
DME Wash. Co. Md. <u>4-10-59</u> <u>S. Robert Wells, M.D.</u> <b>CERTIFICATE OF DEATH</b> 04883									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>4873</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>					c. LENGTH OF STAY IN 1b <u>80 YRS.</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARTIN MANOR REST HOME</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CLEARSRING</u>				
					d. STREET ADDRESS <u>RT.#1 CLEARSRING</u>				
3. NAME OF DECEASED (Type or print) First <u>HESTER</u> Middle <u>ANN</u> Last <u>SWOPE</u>					4. DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>19 59</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/23/1865</u>		9. AGE (In years last birthday) <u>93</u> yrs.	
						IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB KLINE</u>					14. MOTHER'S MAIDEN NAME <u>MARTHA SWOPE</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. VIOLA G. BLOYER</u>		Address <u>CLEARSRING MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Bronchopneumonia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic Heart Disease</u> DUE TO (c) <u></u>									INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of the Right hip incurred in a fall 3/28/59</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>XXXX</u> p.m. <u>Mar 28</u> 19 <u>59</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at home</u>		20f. (City or town) <u>Rural Clearspring</u> (County) <u>Wash</u> (State) <u>MD</u>	
21. I certify that I attended the deceased from <u>March 28</u> 19 <u>59</u> , to <u>April 7</u> 19 <u>59</u> , that I last saw the deceased alive on <u>April 7, 1959</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____									
ACTUAL SIGNATURE <u>Archie Robert Cohen</u> M.D.				PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u> <u>Clear Spring, Maryland</u> <u>April 9, 1959</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS CH. CEM.</u>			22d. LOCATION (City, town, or county) (State) <u>WASHINGTON CO. MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Norment</u> ADDRESS <u>Hagerstown</u>						24a. REC'D BY REGISTRAR <u>APR 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4901

## CERTIFICATE OF DEATH

Reg. Dist. No.

04884

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEEDYSVILLE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X KEEDYSVILLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTE <b>KEEDYSVILLE MD FARM</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CHARLES KEEDY TAYLOR</b>				4. DATE OF DEATH Month Day Year <b>APRIL 24 1959</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DECEMBER 7 1897</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MANAGER-FREDERICKA COLA-COLA PLANT.</b>		11. BIRTHPLACE (State or foreign country) <b>LA CROSSE KANSAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES BAKER TAYLOR</b>				14. MOTHER'S MAIDEN NAME <b>ETTA ELIZABETH KEEDY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-09-6160</b>		17. INFORMANT Address <b>MRS. MARTHA TAYLOR KEEDYSVILLE MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized metastatic Carcinomatosis</b> <b>155.1</b> DUE TO <b>Carcinoma of the Gall bladder</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>8 mos. (9)</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April 24 1959</b> to <b>April 24 1959</b> , that I last saw the deceased alive on <b>April 24 1959</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walter H. Shealy</b>				DATE SIGNED <b>4/25/59</b>			
PHYSICIAN'S NAME (Type) <b>Walter H. Shealy M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>APR 27 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FAIRVIEW CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>KEEDYSVILLE WASH. CO. MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. East</b>				ADDRESS <b>BOONSBORO MD</b>		24a. REC'D BY REGISTRAR DATE <b>APR 30 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1901

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		Male		45		Jan 15, 1856		Baltimore, Md.	
MARRIED		WIFE		NAME		AGE		DATE OF MARRIAGE	
Yes		Mary H. Harris		42		Jan 15, 1859		Baltimore, Md.	
CAUSE OF DEATH		DISEASE		COMPLICATIONS		TREATMENT		DATE OF DEATH	
Heart Disease		Coronary Artery Sclerosis		Hypertension		Digitalis, Nitroglycerin		Jan 10, 1901	
PLACE OF DEATH		RESIDENCE		OCCUPATION		EDUCATION		RELIGION	
Home		1234 Main St, Baltimore, Md.		Clerk		High School		Roman Catholic	
BURIAL		CITY		COUNTY		STATE		DATE OF BURIAL	
Yes		Baltimore		Baltimore		Md.		Jan 12, 1901	
NAME OF MINISTER		NAME OF CLERGYMAN		NAME OF FUNERAL HOME		NAME OF CEMETERY		NAME OF INTERMENT	
Rev. J. J. Harris		Rev. J. J. Harris		J. J. Harris		St. Mary's Cemetery		St. Mary's Cemetery	
SIGNATURE OF DECEASED		SIGNATURE OF WIFE		SIGNATURE OF MINISTER		SIGNATURE OF CLERGYMAN		SIGNATURE OF FUNERAL HOME	
James H. Harris		Mary H. Harris		J. J. Harris		J. J. Harris		J. J. Harris	
DATE OF DEATH		DATE OF BURIAL		DATE OF INTERMENT		DATE OF DEATH		DATE OF BURIAL	
Jan 10, 1901		Jan 12, 1901		Jan 12, 1901		Jan 10, 1901		Jan 12, 1901	

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4902 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04885

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Smithsburg</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X rural Smithsburg</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RFD 2</u>			d. STREET ADDRESS <u>1 RFD 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harrison Francis Walter</u>			4. DATE OF DEATH Month Day Year <u>April 16 1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1888</u>	9. AGE (In years last birthday) <u>70 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Fairfield, Penna.</u>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>Conrad C. Walter</u>			14. MOTHER'S MAIDEN NAME <u>Lucy M. Cool</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-28-3072</u>		17. INFORMANT Address <u>Lawrence E. Walter, Waynesboro, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Obesity</u>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>None 19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	
20f. (City or town) <u>-</u>		20g. (County) <u>-</u>		20h. (State) <u>-</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-17-59</u>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Apr. 18, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Smithsburg, Md.</u>		22e. (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Minnich Funeral Home, Smithsburg, Md.</u>		ADDRESS <u>Minnich Funeral Home, Smithsburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>					

MEDICAL CERTIFICATION

2

BP

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
1902 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

81255

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, occupation, and cause of death. The form is oriented horizontally but contains vertical text in some sections.

NAME: \_\_\_\_\_

AGE: \_\_\_\_\_

SEX: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_

PLACE OF DEATH: \_\_\_\_\_

EXAMINER'S SIGNATURE: \_\_\_\_\_

WITNESSES' SIGNATURES: \_\_\_\_\_

LOCAL HEALTH OFFICER'S SIGNATURE: \_\_\_\_\_

LOCAL HEALTH OFFICER'S TITLE: \_\_\_\_\_

LOCAL HEALTH OFFICER'S ADDRESS: \_\_\_\_\_

LOCAL HEALTH OFFICER'S PHONE: \_\_\_\_\_

LOCAL HEALTH OFFICER'S MAILING ADDRESS: \_\_\_\_\_

LOCAL HEALTH OFFICER'S CITY: \_\_\_\_\_

LOCAL HEALTH OFFICER'S STATE: \_\_\_\_\_

LOCAL HEALTH OFFICER'S ZIP: \_\_\_\_\_

LOCAL HEALTH OFFICER'S COUNTRY: \_\_\_\_\_

LOCAL HEALTH OFFICER'S TELEPHONE: \_\_\_\_\_

LOCAL HEALTH OFFICER'S FAX: \_\_\_\_\_

LOCAL HEALTH OFFICER'S E-MAIL: \_\_\_\_\_

LOCAL HEALTH OFFICER'S WEBSITE: \_\_\_\_\_

LOCAL HEALTH OFFICER'S SOCIAL MEDIA: \_\_\_\_\_

LOCAL HEALTH OFFICER'S OTHER CONTACT INFORMATION: \_\_\_\_\_

LOCAL HEALTH OFFICER'S SIGNATURE: \_\_\_\_\_

LOCAL HEALTH OFFICER'S TITLE: \_\_\_\_\_

LOCAL HEALTH OFFICER'S ADDRESS: \_\_\_\_\_

LOCAL HEALTH OFFICER'S PHONE: \_\_\_\_\_

LOCAL HEALTH OFFICER'S MAILING ADDRESS: \_\_\_\_\_

LOCAL HEALTH OFFICER'S CITY: \_\_\_\_\_

LOCAL HEALTH OFFICER'S STATE: \_\_\_\_\_

LOCAL HEALTH OFFICER'S ZIP: \_\_\_\_\_

LOCAL HEALTH OFFICER'S COUNTRY: \_\_\_\_\_

LOCAL HEALTH OFFICER'S TELEPHONE: \_\_\_\_\_

LOCAL HEALTH OFFICER'S FAX: \_\_\_\_\_

LOCAL HEALTH OFFICER'S E-MAIL: \_\_\_\_\_

LOCAL HEALTH OFFICER'S WEBSITE: \_\_\_\_\_

LOCAL HEALTH OFFICER'S SOCIAL MEDIA: \_\_\_\_\_

LOCAL HEALTH OFFICER'S OTHER CONTACT INFORMATION: \_\_\_\_\_

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4874

## CERTIFICATE OF DEATH

04886

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington Co.</u> <u>Md.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>9-30-58/4/8-59</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md. State Hospital</u>			d. STREET ADDRESS <u>1606 E - Fleet ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>L.</u> Last <u>Walters</u>			4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1959</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1901</u> <u>57</u> yrs.		9. AGE (In years last birthday) <u>57</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Raleigh, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>Charles Hunt</u>		
14. MOTHER'S MAIDEN NAME <u>Annie</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>✓</u>			17. INFORMANT <u>Mrs. Doris Sullivan</u> <u>2809 E. Fairmount</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY CONGESTION &amp; EDEMA</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALISED CARCINOMATOSIS</u> DUE TO (c) <u>SQUAMOUS CELL CARCINOMA OF CERVIX</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>3 MONTHS</u> <u>16 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Sept. 30</u> , 19 <u>58</u> , to <u>April 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 8</u> , 19 <u>59</u> , and that death occurred at <u>7:45 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Victor L. Ramos</u>		M.D. <u>Western Md. State Hospital</u>		DATE SIGNED <u>April 9/59</u>	
PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS</u>		<u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-10-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>APR 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					





4903

# CERTIFICATE OF DEATH

04887

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hancock Md</b>		c. LENGTH OF STAY IN lb <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hancock</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>				d. STREET ADDRESS <b>Rural 2 Hancock Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Edith</b>		Middle <b>Amelia</b>		Last <b>Weller</b>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month <b>4</b> Day <b>30</b> Year <b>19 59</b>	
9. AGE (In years last birthday) yrs. <b>72</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Washington Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Not Known</b>		14. MOTHER'S MAIDEN NAME <b>Ida Shives</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Nina Wilson Hancock Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15-20 min</b> <b>20 yrs</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 7, 1958</b> , to <b>April 30, 1959</b> , that I last saw the deceased alive on <b>April 29, 1959</b> , and that death occurred at <b>7:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Frank B Thomas III M.D.</b>		M.D. <b>121 High Street</b>					
PHYSICIAN'S NAME (Type) <b>Frank B. Thomas III, M.D.</b>		<b>Hancock, Maryland</b>					
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5.3.59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Stone Bridge Brothers</b>		22d. LOCATION (City, town, or county) (State) <b>Near Hancock Washington Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hancock &amp; Shore Hancock Md</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>MAY 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kline</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
ISM 10/57

ARMY AND STATE DEPARTMENT OF HEALTH-CALIFORNIA 10

Figure 1

4875

## CERTIFICATE OF DEATH

04888

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>9 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b> d. STREET ADDRESS <b>Route 2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lewis Henry Wiebel III</b>		4. DATE OF DEATH <b>April 10 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 23, 1906</b>
9. AGE (In years lost birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Augustus Wiebel</b>		14. MOTHER'S MAIDEN NAME <b>Mattie O. Tushbaugh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-20-0721</b>	
17. INFORMANT <b>Mrs. Mary B. Wiebel</b>		Address <b>Route 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Sclerosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>nephrosclerosis, uremia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 day</b> <b>indef</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Mar 7, 1959</b> to <b>April 10, 1959</b> , that I last saw the deceased alive on <b>April 9, 1959</b> , and that death occurred at <b>4:35 a.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert M. Campbell</b> M.D.		ADDRESS (Street, city or town, state) <b>145 W. Washington St.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Robert V. Campbell</b>		<b>Hagerstown Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-12-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. H...</b>	

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11500

CERTIFICATE OF DEATH

275

Washington

Washington

Washington

Register

2 days

Register

Washington County Hospital

10

April 11

Henry Lewis

Jan. 23, 1900

Male

U. S. A.

Register

Register

Register

Register

Register

Register

219-20-0721

NO

100 N. Washington St.

Register

Register

Register

Register

Register

Register

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4904 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04889

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wash	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro	c. LENGTH OF STAY IN lb 3 1/2 mos	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Highfield	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Reeder Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clara Easter Willard		4. DATE OF DEATH Month Day Year Apr. 14 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1875
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Wesley McAfee	
14. MOTHER'S MAIDEN NAME Hannah Brown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No no	
16. SOCIAL SECURITY NO. 215-18-2203		17. INFORMANT Address Reeder Nursing Home - Boonsboro, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular renal disease 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes M (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrene foot			INTERVAL BETWEEN ONSET AND DEATH 10 yrs
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. None 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) (County) (State) - - -
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Jack H. Beachley, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4-15-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-17-59	22c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery	22d. LOCATION (City, town, or county) (State) Foxville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR DATE APR 20 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	



1000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10000

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is partially filled out with handwritten text.

NAME: [Handwritten Name]  
AGE: [Handwritten Age]  
SEX: [Handwritten Sex]  
RACE: [Handwritten Race]  
OCCUPATION: [Handwritten Occupation]  
CAUSE OF DEATH: [Handwritten Cause of Death]

Vertical text on the right margin, likely a filing or tracking number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4876

## CERTIFICATE OF DEATH

04890  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mr Smithsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS N. Main St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Harvey Edward Williard		4. DATE OF DEATH Month Day Year April 22, 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1918
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mason		10b. KIND OF BUSINESS OR INDUSTRY construction work	
11. BIRTHPLACE (State or foreign country) Lantz, Fred. Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert D. Williard		14. MOTHER'S MAIDEN NAME Virgie A. Bowman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-10-3954	
17. INFORMANT Address Joseph W. Williard Smithsburg, Rd1, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 322.2 Constrictive heart failure DUE TO (b) Lobar pneumonia DUE TO (c) Alcoholic intoxication Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 day 2 days 1 wk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-3-54, 19, to 4-22-59, 19, that I last saw the deceased alive on 4-22-59, 19, and that death occurred at 11:40 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Charles F. Hess		M.D. Smithsburg, Md. 4-23-59	
PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 4-25, 1959	22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cem	22d. LOCATION (City, town, or county) (State) Smithsburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR DATE APR 27 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thacker	



4877

## CERTIFICATE OF DEATH

04891

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>		c. LENGTH OF STAY IN 1b <b>20yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		/ d. STREET ADDRESS <b>400 B Park Place</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Ezekiel Wilson</b>		4. DATE OF DEATH Month Day Year <b>4 3 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 5 1905</b>
9. AGE (In years last birthday) <b>54 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Res Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>Charlestown W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Magie Wilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>236-14-1057</b>	
17. INFORMANT <b>Mary E. Wilson</b>		Address <b>400B Park Place.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>527.1 Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Pulmonary emphysema and bronchial asthma</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>22 hours</b> <b>1 year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 2</b> , 1959, to <b>April 3</b> , 1959, that I last saw the deceased alive on <b>April 2</b> , 1959, and that death occurred at <b>12:15</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>M.D. 100 Professional Arts Bldg. 4/4/59</b>			
ACTUAL SIGNATURE <b>William T. Layman</b>		PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D. Hagerstown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-5-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Watson Jr. Hagerstown Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 7 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Charles E. Kraus</b>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4878

## CERTIFICATE OF DEATH

04892

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>439 W. Franklin Street</b>	
3. NAME OF DECEASED (Type or print) <b>MARY CATHERINE WOLFE</b>		4. DATE OF DEATH <b>April 3 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 10, 1871</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>4</b> Days <b>23</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Floor Lady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Commercial Laundry</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel H. Switzer</b>		14. MOTHER'S MAIDEN NAME <b>Mary J. Lawrence</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-18-1337</b>	
17. INFORMANT <b>Edgar W. Wolfe</b>		Address <b>Baltimore, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b> <b>Indefinite</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 23, 1959</b> to <b>April 3, 1959</b> , that I last saw the deceased alive on <b>April 2, 1959</b> , and that death occurred at <b>10:55 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B. B. Kneisley</b>		ADDRESS (Street, city or town, state) <b>148 West Washington St. Hagerstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. B. B. Kneisley</b>		DATE SIGNED <b>4/4/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/6/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rome Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Kouzer Funeral Home</b>		24a. BY REGISTRAR <b>APR 8 1959</b>	
ADDRESS <b>Hagerstown, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Carroll L. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1938

1938

1938

Washington

Washington County

Washington County

MARY

DECEASED

White

October 10, 1938

Washington County

Washington County

Washington County

Washington County

1

Washington County

Washington County

Washington County

Washington County

1938

Washington County

Washington County

1938

Washington County

Washington County

Washington County

Washington County

Washington County

Washington County

Washington County

Washington County

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4879 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04893  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN	
c. LENGTH OF STAY IN 1b 6YRS.		d. STREET ADDRESS 1327 MITCHELL AVE.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE WILLIAM YOUNGBLOOD		4. DATE OF DEATH APRIL 23 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/1889
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LINEMAN		10b. KIND OF BUSINESS OR INDUSTRY ELEC. POWER CO.	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ADAM YOUNGBLOOD		14. MOTHER'S MAIDEN NAME LOUISE WHORTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-10-5334	
17. INFORMANT Address HAGERSTOWN MD.		MRS. EMMA W. YOUNGBLOOD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO acute coronary thrombosis Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial asthma		INTERVAL BETWEEN ONSET AND DEATH 10 min	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 25 19 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/26/59	
22c. NAME OF CEMETERY OR CREMATORY GREENWAY CEM.		22d. LOCATION (City, town, or county) (State) BERKLEY SPRINGS W. VA.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. J. Horne, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE APR 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04894

4905

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>20days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Henry Zepp Jr.</b>		4. DATE OF DEATH <b>April 13 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1900</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sand Blast</b>	
11. BIRTHPLACE (State or foreign country) <b>Martinsburg W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John H. Zepp Sr</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Green</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address: <b>Mrs. Catherine Rickard Hag. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>421.4 Acute Cardio Vascular Dis</b> DUE TO (b) <b>Chr. Valvular Dis</b> DUE TO (c) <b>Chr. Valvular Dis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hemiplegia Rt side</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar 20, 1959</b> to <b>April 13, 1959</b> that I last saw the deceased alive on <b>April 13, 1959</b> and that death occurred at <b>6 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David R. Brewer</b> M.D.		ADDRESS (Street, city or town, state) <b>Clear Spring Md.</b> DATE SIGNED <b>4/15/59</b>	
PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>		<b>Clearspring Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-17-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 20 59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Thomas</b>	



Robert F. Minnich & Son, Lagershausen -

Gravel

4-12-22

Rose Hill Cemetery

Lagershausen -

David H. Brewer

Disinterred

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page.]*

Mrs. Catherine Richard, U.S. No.

John H. Lang, Jr.

Catherine Green

Widow

Sam Hines

Martinsburg, W. Va.

U. S.

Wife

White

June 22, 1900

58

John Henry Lopp, Jr.

April 13

188 Williams -

Calway Nursing Home

Lagershausen

30035

Lagershausen

Lagershausen

Lagershausen

Washington

4905

DEPARTMENT OF DEATH

1884